			1 - For State Registrar	State of Mai		artment rtificate			nd Me		giene	007	02001
	Physi	cian	Decedent's Name (First, Middle, L.	,						2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Med Exam		VIOLET 4a. Fecility Name (If not institution, g		ONTS	4b Ciby	Tour or	Location of		January		2007	10:50 P M
	ZXaiii	liter	Friends Nursin	,		_		Spring				inty of Death	
	Funera			Sex 7. Age	(In yrs. last birthday)	If Under Months		If Under 24	Hrs.	8. Date of Birtl	h	ntgome 9. Birth	place (State or Foreign
	Directo	r	233-20-9799	1□M 2□ F	93 Yrs.	Months	Days	nours	Min.	(Month, Da)	-1913		NV
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	cation							10d. Inside City Limits
	Mary a-f sh	ţ	MD Montgon	ery	Sandy S	pring							1 ☐ Yes 2 ☑ No
	ath with the Marylan 23s or 28s-f show	irec	10e. Street and Number			10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	ath w	Funeral Director	17401 Norwood Ro	oad		20	860				US	SA	
	er de	une	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Deced	ent of His	spanic Origin n, Mexican, f	? (Spec	rify Yes or No-	14.	Race - Ameri Black, White,	
336	within 72 hours after death with the Maryland ene. then "netural" or items 23e or 28e-f show the Maulical Examinant he motilled at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛱 No If Yes, Give Year or Dates:		1 ☐ Yes 2	⊠ No	Specify:			1		nite
9	72 hou	ted	15. Decedent's	ducation	16a. Dece	dent's Usua	Occupa	tion			16b. Kind o	f Business/In	idustry
215	ithin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of won DO NOT us	done d	urina most o	f workin	g		. 2001103211	dustry
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anc	s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked other then other traumatic event, the most	Be	17. Father's Name (First, Middle, Las							(First, Middle,	Maiden Sun	name)	
<u> </u>	should nd Me mark imatic	2	Lundy John Gad 19a. Informant's Name/Relationship		10b Mailie	a Addrosa	(Stroot o		a Ca	Route Numbe			
≥	alth a 27 is		John J. Coonts/							lton, l		wn, State, 21, 1759	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition		20b. Place of Disno	sition (Nam.	e of		Da	-		on - City or To	own, State
Ë	Page ment ant: ii ury o		1 ⊠Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State (fy)	Lambert Cemetery	Chape.	- piace	01	-24-	-2007	Relin	eton	WXX
3alt	Depart Depart Import any inj		21. Signature of Faneral Service Lice	ns)				of Facility	Pol:	ing-St	Clair	Funer	al Home
	7 D F # 0		23a. Part1. Enter the disease, or con	oww						., Buck		n, WV	26201
	hysicien and hysicien and physicien and physicien and physicien and the physicien an	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last		unsequence of):	ction							Interval Between Onset and Death
	it the death certif by the ettending tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	∃Fetal déath 3 □	Ectopic pred						Date of delive Month	ery Day Year
ords, F	n requires tha been signed should be de	Ď	Part II, Other significant conditions	contributing to death but n	ot resulting in the un	derlying cau	ise giver	in Part I.			oacco use co		ne cause of death? ably 4 ⊠Unknown
Division of Vital Records,	it cien: The law i certificate hes b rector, page 2 sh	Completed							-	24a. Was a autops perform	v	prior to cor death?	psy findings available inpletion of cause of
× ×	ysician: is certific director,	- 00 €	25. Was case referred to medical examiner?	Hospital:			1 -		-yarda bar	Check only on			
o i	g Phys er this eral di	7.	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Unpatient	2 ER/Outpatient		Other	4 KU NUISIR		5 Reside			v)
ion	5 . 5 5	tior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Ye	ear) Injury	м 200	Unjury a Work?	u s 2 ⊡No	28	d. Describe ho	w injury occ	urrea	
Divis	nospital or Attand 24 hours efter death Funeral Diractor; A stely filled in by the t	Certification:	3 Suicide 6 Could not b		- At home, farm, stre Specify)				28	f. Location (Sti City or Town	reet and Nur , State)	mber or Rura	l Route Number,
4	ਵੁੱਦੇ <u>ਕ</u> ੍ਰੈ	ledical	one)	ysician: To the best of m niner: On the basis of exa and manner stated	annon and/or invi	occurred at estigation, in	the time my opir	, date and plain, death o	lace, and	d due to the ca at the time, da	use(s) and i	manner as st e, and due to	ated. the cause(s)
	5 ¥ 5 6	-	29b. Signature and title of certifier				icense r			29	d. Date sign	ned (Month,	Dey, Year)
	/		- Cruskost	ayuus >			9793				Janua	ry 19,	2007
	り		30. Name and address of person who Christopher J. Ma	completed cause of death			Dr.	1 !		0.1			
	Sta Registra	1	31. Date filed (Month, Day, Year) JAN 2 6	32. Progistrar's	18111 P	MALL	rn1	11p Di	.,_	Ulney,	MD 2	0832	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Amend #20A&b Registrar	Per FH C863	pariment of Heal Prificate of Dea	ith and Menta a <i>th</i>	ıı mygleri Reg. N	e •2007	02002
	Dhusisi		Decedent's Name (First, Middle, Last)	01-0		2. Dat	e of Death	av Year	3. Time of Death
4	Physici /Medic		Karen	Carter	Ab City Town and and	70		6 2007	716 AM
•	Examin	er	4a. Facility Name (If not institution, give s University of Harylond		4b. City, Town, or Local Baltimor		4	c. County of Death	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year If U	Inder 24 Hrs. 8. Dat	e of Birth onth, Day, Yea	9. Birthp	lace (State or Foreign try)
	Director		Usual Residence of Decedent	M 200 F 4 / Yrs		JA.	N. 12,19	966 MA	RYLAND
	yland now at		10a. State 10b. County	10c. City, Town or	0			1	Od. Inside City Limits
	8a-f sl	Director	MARYLAND N.	/A	BALTIM	IORE C	ITY	Shines of 18th of Court	1 X Yes 2 No
	with the		10e. Syfeet and Number	MOY STREET	10f. Zip Code	1217	riog. C	Citizen of What Coun	nry:
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specify Ye exican, Puerto Rican,	es or No-	14. Race - Americ Black, White,	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show kiteal Examiner must be notified at	by Fu	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Sp		ŕ	Specify:	INOV
9	2 hour	ted k	15. Decedent's Edu	cation 16a. De	ecedent's Usual Occupation	a most of working	16b.	Kind of Business/Inc	dustry
21215-0036	be filed within 72 horal Hygiene. d other than "nature event, the Merical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	rive kind of work done during e. DO NOT use retired)			45/1	
d 21	filed w Hygie other th		17. Father's Name (First, Middle, Last)) 15 ABLE [18.	Mother's Name (First,	Middle, Maide	en Surname)	
Maryland	2 should be and Mental Is marked o	To Be	HOWARD	Russ	SELL G	WENDO	LYN	CA	RTER
Jan	and and aum	ľ	19a. Informant's Name/Relationship (Ty	1 / /	ailing Address (Street and N	Number or Rural Route	Number, City	or Town, State, Zip	Code)
	1 an Heal PH 2		JAMICA (5/2/2 20a. Method of Disposition	U S (DAUGHTER) O a	sposition (Name of arrange of the contraction)	PALK /4VE Date	20c.	<i>MOKE, M</i> Location - City or To	D. Z. / Z Z Z own, State
E	0		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removal from State	1 / Cemelen	11-29-6	97 B.	ALTIHOR	E. MD
Baltimore,	permit. Pag Department Important: I any injury o once,		21. Signature of Funeral Service License		22. Name and Address	Facility BROWN	NJK		AL HOME
	<u> </u>		23a Part 1 Enter the disease or compl	p, f) care	enter the mode of dving, su	CULTON /		SALTO, M.	O. ZIZIZ Approximate
	Physician		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line. Metabolic aci			,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of)					
	Examiner	<u>-</u>	Sequentially list conditions,	Due to (or as a consequence of)					
	uted	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events						
90,	cate be executed physician and the burial-transit	I Exa	that initiated events resulting in death) Last	Due to (or as a consequence of)					
68760,	ificate be executed g physician and as the burial-transit	edical		d					
Box (IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy	3 □Ectopic pregnancy			23d. Date of delive	
	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			Month	Day Year
P.0	res that the de signed by the a be detached t		Part II. Other significant conditions co	ntributing to death but not resulting in the	ne underlying cause given in	Part I. 23	Be. Did tobacco	o use contribute to t	he cause of death?
rds	w requires been sign should be	ed by					1 ☐ Yes	2 No 3 Prob	pably 4 Unknown
or Vital Records,	law re as bee	Completed				24	la. Was an autopsy	24b. Were auto	opsy findings available mpletion of cause of
a B							yes 2□1		2 □ No
. XII	Physiclan: this certificral director,	To Be	25. Was case referred to-medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outp	Other	Place of Death (Che		6 ☐Other (Special	(v)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at		escribe how in		
Division	if or Attending after death. Director: After in by the fune	icatic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At home, farm	M 1 ☐ Yes		cation (Street	and Number or Rura	al Route Number.
<u>≥</u>	al or A	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	, 0, 0		ty or Town, Sta		
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Exam	sician: To the best of my knowledge, of the control of the basis of examination and/					
	o the lathin 2.	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License nur	mber	29d. [Date signed (Month,	Day, Year)
	L S F O		> & Nayan	MD	P212	-12	Jo	an 16 a	2007
7	7		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty	/pe, Print)	Nayuk			
C	St	ate	22 S. Gircene St 31. Date filed (Month, Day, Year)	Bultimore HD 21 32. Registrar's Signature		11044			
+	Regist		JAN 2 6 20	/A Z	COARLY				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9863 1-26-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** Marva 10:21AM January 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Randallstown Hospital Center Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 X F 08 Months Hours Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentlal Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Mandallstow. Director altimore 10e. Street and Number 10g. Citizen of What Country? USA 14. Race - American Indian, 2//33

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Cinnaman C HPT Funeral ircle 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tealth Attendant Social Concern 17. Father's Name (First, Middle, Last) UNKnown 18. Mother's Name (First, Middle, Maiden Surname) Be P boothy Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 380 Giralda Avenue. April Carter / 20a. Method of Disposition 1 ables FL 33134 20c. Location - City or Town, State Coral Gables, FL Doughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 2007 Veirice United Methodist Ol. 30 - 2004 Veirice PA
22. Name and Address of Facility Vougan C. Green Fund of Service 21. Signature of Funeral Service Licensee 728 Liberty Rd Randallstown, IND 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): stage disease or condition resulting in death) /Medical Examiner Multiple organ System

Due to (or as a consequence of): Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the cau Examine ystemic inflammator The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Gastric aspiration IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by failure, Chronic 1 Yes 2 No 3 Probably 4 Unknown Severe protein calorie malnutrition, Constipation (impact 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed Yes 2 No Immobility syndrome, of certificate Anemia chronic illness 1□ Yes Physician; To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Medical Certification: To 27. Magner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28462 Januar 24,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T Boston Northwest Hospital Center Randallstown, Maryland Boston 31. Date filed (Month, Day, Year) 32. gistrar's Signature State JAN 26 2007 Registrar Const.

		•	1- State of Maryland / Department of Health Certificate of Death		Reg. No.	007 02004
			1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death Day	3. Time of Death
П	Physicia /Medic		Howard H. Conway	Janua	01	2007 4:00 P M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	of Death	4c. C	ounty of Death
			649 Colston Lane Pasadena	ı		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	Min. 8. Date of	Birth Day, Year)	Birthplace (State or Foreign Country)
	Director		217-01-1229 112/M 2 F 89 Yrs. Months Days Hours	Jan.	16,191	8 Maryland
Т	D.		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	aryla ehov	5	704.014.0			1 □Yes 2 12 No
	8a-1	ctc	Maryland Anne Arundel Pasadena		10a Citiza	on of What Country?
	Vith th	Director	10e. Street and Number 10f. Zip Code		iog. Citize	or what country?
	234	ra	649 Colston Lane 21122	rigin? (Specify Vec or	No. 14	U.S.A. I. Race - American Indian,
	er de	nu	Armed Forces? If Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)		Black, White, etc.
36	rs aft	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No Specify 3 □ Widowed 4 □ Divorced Year or Dates:	y:	S	Specify: White
Ş	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "naturel", or lieme 23a or 28a-f ehow event, the Madiral Examinar rotal be mulliad at	ed	15 Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind	d of Business/Industry
5	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during mo life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	ost of working		
212	with jene r tha	E	12 N/A Shipfitter		U.S	. Coast Guard
פ	other	BeC	17. Father's Name (First, Middle, Last) 18. Moth	her's Name (First, Mid		
a	lenta fenta rked rked	To B	Glenn Ellsworth Conway Car	rie	Viol	a Chaney
ary	should ind Men marke umatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)		mber, City or	Town, State, Zip Code)
Ž	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Iteme 23a or 28a-1 show or other treumatic event, the Madical Examinar must be notified at		Virginia C. Williams (Daughter) 649 Colston Lane	Pasadena.	Maryla	nd 21122
ē,	t Hein Item		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Loca	ation - City or Town, State
Ë	Page sent c nt: If ry or		1 □ Burial 2 1 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory	1/25/07	Balt	imore Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 it any Injury or other tre <u>phce</u> .	1	21. Signature of Funeral Service Licensee 22. Name and Address of Faci	ility		
ä	Depa Impo any It		John Fr Collins McCully-Polyni 3204 Mountain	Road Pasad	Home, lena. M	P.A. Maryland 21122
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	s cardiac or respirator	y arrest,	Approximate Interval Between
Ų.	Physician		Immediate Cause (Final disease or condition On 60 Style NG (h Lin	1 14	Onset and Death
7	/Medical		resulting in death) Due to (or as a donsequence of):	4 120	(CVC)	
	Examiner			·		
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	cuted nd ransi	Examiner	that initiated events C.			
oʻ	an ar	Ä	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed to attending physician and of for use as the burial-transit	dlcal	d			
9	certifica anding pl use as t	Wed	IF FEMALE:			
Вох	ath certif attending for use a:	an/l	23b. Was decedent pregnant in the past 12 months?		23	3d. Date of delivery Month Day Year
	the at	sici	1 Tyes 2 No 9 Información de all 5 Other (specify)		- 1	,
0.0	by tac	Physician/Me	9 Unknown	220 [hid tobacco us	e contribute to the cause of death?
	8 5 9	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		Yes 2	\/
ord	w requires been sign should be	ed d			THS 2L	TNO 3 Probably 4 Polikiowii
ecc	2 S X	ple		24a. V	utopsy	24b. Were autopsy lindings available prior to completion of cause of
Ě	0 - 9	Completed		1 P	erformed? s 20 No	death? 1 ☐ Yes 2 No
Division of Vital Records,	Physician: Th rthis certificate ral director, pag	Be	avaminer?	ce of Death (Check or	nly dne)	
<u></u>	00	၉	1 Yes 2 To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N			Other (Specify)
0	ng Pl		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of linjury 28c. Injury at Work?	28d. sd	e how injury	occurred
010	Attending r death.	ati	2 Accident investigation M 1 Yes 2 L			
₹	isl or Attending Phy s aftar death. Il Director: After this ed in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)		on (Street and Town, State)	Number of Rural Route Number,
Ω	ital c					
	To the Hoepital or Atta within 24 hours aftar de To the Funeral Directo completely filled in by th	ca	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date a (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de			
	To the Ho within 24 I To the Fu completely	Medical	29b. Signature and tile Abertifier 29c. License number		29d Date	signed (Month, Day, Year)
		-	29b. Signature and title of tertifier	. 1	1	つ (- かつ
Ţ			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	x-1	1	13-04
1	0		30. Name and address of p (5) who sumpleted cause of death (Item 23a) (Type, Print)	11110	1.0 6	1 110 7/101
			31 Date field (Marth Day Year)	MUIN M	197	rown my lill
	Sta Regist	ite rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			1
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DH	MH 17 Rev 1/2	CHIT				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland / Department of Health and Mental Hygiene per dr., G863, OI/26/07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dora Dragos /Medical 2007 001 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Modreal Unter MINNISTY more 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🗓 F Hours 84 216-16-1701 4-7-1922 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Anne Arundel Brook1vn Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 516 Old Riverside Road 21225 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Phone Company permit. Pages 1 and 2 should be filed wi.
Department of Health and Mental Hygien.
Important: If Item 27 is marked other the
any Injury or other traumart. Telephone Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Behr ပ Lillian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol Carpenter/daughter 837 Evergreen Rd., Severn_MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery | 1/24/2007 Dundalk, MD 4 Donation 5-Other (Specify) 27. Signature of Funeral Service Lices 22. Name and Address of Facility Singleton Funeral Home PA M01364 1 Second Ave SW Glen Burnie MD 21061 P 111. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MADCSAG /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Justo (or as a consequence of, Examine the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 Other (specify) detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? certificate 2☑ No 1□ Yes

Box 68760 Division or Vital Records, P.O.

To the Hospital or Attending Physician: within 24 hours arter control to the Funeral Director: Aft

> State Registrar

Be

P

Certification:

Medical

After this c

25. Was case referred to medical

5 Pending investigation

6 ☐ Could not be

determined

22

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 🗹 Natural

2 ☐ Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Pay, Year) JAN 2 6 2007

Mic

3 ☐ Suicide

29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Street

32. Registrar's Signature

28h Time of

28c. Injury at Work?

1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore, Maryland

29c. License number

P19840

1 Yes 2 No

28a. Date of Injury (Month, Day Year)

M.D

South Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26. Place of Death Check onl one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jan 21.2007

29d. Date signed (Month, Day, Year)

			For	State of Maryla				•	jiene	02006
			1 - State Registrar		Cer	tificate of L	Death	F	leg. No.	02000
п	Physici	an	1. Decedent's Name (First, Middle, Last) Anna Justine I	>				Date of Dea Month	th Day Yea	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give s.			4b. City, Town, or	Location of Death	Januar	23,20 4c. County of D	
	Examir	ier	705 Country Vil		≥ 1-B	Bel Ai			Harfo	
	Funeral		5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9.1	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 200F	79 Yrs.			Feb. 7	,1927 Ui	niontown, AL
	yiand now		10a. State 10b. County	10c. C	ity, Town or Loc	cation				10d. Inside City Limits
	an-fs	ctor	MD Harford	Be	el Air					1 ☐ Yes 2 No
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 show the Midical Examination of the Midical	Funeral Director	705 Country Vil	lago Drive	. 1 5	10f. Zip Code		1	0g. Citizen of What USA	Country?
	ns 23	erai		2. Was Decedent Ever in U		21050	spanic Origin? (Sp	ecify Yes or No-		merican Indian,
9	after or ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	Vas Decedent of His Yes, specify Cubar		Rican, etc.)	Black, W	hite, etc.
8	hours 'ural',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:		☐ Yes 2 No	Specify:		Specify:Wt	
21215-0036	in 72 n "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	ent's Usual Occupa kind of work done di ONOT use retired)	uring most of worki	ing	16b. Kind of Busine	ss/Industry
212	d with giene er than	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen	aker			At Home	•
Maryland	should be filed within 72 hours after death with the Marylar of Mental Hygiene. marked other than "natural", or items 23a or 28a-1 show imatic event, the Medical Examinar must be conflicted.	Be	17. Father's Name (First, Middle, Last) Joseph Tucker				18. Mother's Name		,	
2	thould d Mer marke matic	٦	19a. Informant's Name/Relationship (Typ	a Print)	19b Mailin	Address (Street a	Claudi			T- 0-4
	nd 2 salth an 27 is rtrau		Maryanne Tarasc		r 3 Vi	llare C	t Pol	A + - NUT	, City or Town, State	e, Zip Gode)
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition	200.	Place of Dispos	ition (Name of		Air, Mi	20c. Location - City	or Town, State
Ë	ment ment ant: I		1 Burial 2 □ Cremation 3 □ Re 14 □ Donation 5 □ Other (Specify)	moval from State Alm	Compton	atory`or other place ISC Church Z	1100			e Al-Abama
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Sign ture of Furieral Service Licensed	FIMUR	22.	Name and Address	of FacilityEvans port Drive	: Funeral Forest Hi	Chapel & Cro 11, Marylan	emation Services 1 21050
			23a Part . Enter the disease, or complic slock, or heart failure. List only one		th. Do not ente	r the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate
	Pnysician		Immediate Cause (Final disease or condition resulting in death)		ancre	athe C	aneer	with	liver and	Onset and Death
	/Medical Examiner			Due to (or as a consec	quence of):					
	-0	ner	Sequentially list conditions, b. cause. Enter Underlying	Due to (or as a consec	quanca ory:					
δ.	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
760,	be executed sician and burial-transit	icai E		Due to (or as a consec	quence of):					
687	g phys as the		d.							
XOX	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Med	200. Was dooddon program	c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		ctopic pregnancy			23d. Date of d	elivery
O. B	at the dea by the at tached fo	ysici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of c 9☐ Unknown		Other (specify)			Month	Day Year
٦.	de de	V Ph	Part II. Other significant conditions conti	ibuting to death but not res	sulting in the und	derlying cause giver	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ecords,	w requires been sign should be	ed by						1 □ Ye	s 2 No 3	Probably 4 Unknown
ဝင္ပဝ	law re as bee 2 sho	ompleted						24a. Was ar		autopsy findings available
r		Соп						autops perform 1 Yes 2	ned? death?	completion of cause of es 2 No
Vital	sician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	spital:			26. Place of Death			
ō	Phys or this oral di	on: To	27. Many of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3□ DOA 28c. Injury a	4 ☐ Nursing Hon	ne 5 Reside	nce 6 Other (Sp w injury occurred	pecify)
Ö	ttending l death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work?	es 2 🗆 No		, , ,	
Division	ire in	ertificati	3 Suicide 6 Could not be determined	28e. Place of Injury - At h. building, etc. (Specif	ome, farm, stree	et, factory, office	2	8f. Location (Str City or Town	eet and Number or I , State)	Rural Route Number,
_	Hospitel	0	29a, Certifier 1 Certifying Physic	rians To the best of my kee	outodan death		4-4			
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	(Check only 2 Medical Examine one)	cian: To the best of my kno r: On the basis of examina and manner stated.	ation and/or inve	estigation, in my opin	n uate and place, a nion, death occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	A 4 A		29c. License	number	29	d. Date signed (Moi	nth, Day, Year)
	.2		Siman Re			057	103		123/07	
	1		30. Name and address of person who com	·	n 23a) (Type P	use Dr	we B	saltren	ne M	0 21237
	Sta		31. Date filed (Month, Day, Year)	22. Registrar's Signa	ature		/		,	,
Dhi	Registra MH 17 Rev 1/20		JAN 2 6 2007	Alexan S.	Spark					
	1107 1/20	w 1			77					

Anna Justine Davis TOD

07-00568 Diane G. Deal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 02007

		For State			1	Cert	tificate of	Death				Reg. No.	£ V		1 01.00	, '
Physician	_	egistrar Decedent's Nam	e (First, Middle	e,Last)						2	2. Date of De Month	Day	Year		3. Time of Death 0245 hrs	١
lical Examin	-	Diane									January	21, 200			0245 1115	ļ
	4	4a. Facility Name (if not institutio	n, give stree	t and number)		4b. City, Town,	or Location	of Death		40	. County of	Death		
		Johns Hopk	kins Bayvie	•W				Baltimore			1		===0000	O. Dist	hplace (State or	-
Funeral	7	5 Social Security	Number	6. Sex	7. A	ge (In yrs. Ia	st birthday)	If Under 1 Ye	ear If Und	_	8 Date of B			Foreign	n	
Director	-	212.84.	1202	1 M	2 SF	44	Yrs		ays Hours	S IVIIII	02.1	6.1	962	Cou	untry) MD	
	-	Usual Residence of	of Decedent												10d. Inside City Limits	-
au à	L-	10a. State	10b. County			10c. City,	Town or Loca	ion							1 Yes 2 Mo	
ž .		MD	Bal	timor	·e	В	altim	ore								
Aaryland 28a-f show 1 at once.	ま	10e. Street and Nu				1		10f. Zip Code				10g. Cit	izen of Wh	at Coun	itry?	
e Ma or 28 Ted 8	Director	7953 Ea	st Ba	ltimo	re S	treet		212	24			U.	S.A.			
nith the Maryland 5.23a or 28a-f show notified at once.		11. Marital Status			Was Decede		S. 13. W	as Decedent of	Hispanic Or	igin? (Spe	ecify Yes or I	Vo-	14. Race White		can Indian, Black,	
ath w	uneral		ried 2 N	larried	Armed Force Yes	s?	lf '	es, specify Cut	an, Mexica	n, Puerto i	Ricari, etc.)		VVIIILE		710 4 4 0	
er de	ᄔᅵ	3 Widowed	4 Div	vorced of Yes	, Give Year	2 110	1	Yes 2					Specify:		Nhite	_
rs aft	<u>a</u>	15. Decedent's E		orus	ites:	ompleted)	16a. Decede	nt's Usual Occu nost of working	pation (Give	e kind of w	ork done	16b.	Kind of Bu	siness/l	ndustry	İ
17215-0036 Id be filed within 72 hours after death withen 18 hours after death withen Hygiene narked other than "natural", or items event, the Medical Examiner must be event.	Completed	Elementary/Sec	condary (0-12)		college (1-4 c	or 5+)			ille. DO 140	1 036 1611	caj				4.	
36 thin 72 than than	힐	12					Cat	ering			E (0.1				ality	4
21215-0036 uld be filed within 7 Mental Hygiene marked other that	녌	17. Father's Name		e, Last)					1		(First, Middl		n Surname	ł		
21215 uld be file Mental H marked c	Be	Joseph 19a. Informant's N	ı Stel	la					Gr	ace	Sergi		- T-	- Ctat	Zin Code)	4
	ျ						19b. Maili	ng Address (S	treet and Nu	umber or R	kurai Route r	umber, u	City of Tow	n, state	21224 Lmore, MD	
MD d 2 shot lith and n 27 is sumatic		Ronald		/Hus	pand		7943	East Osition (Name of	Balt	<u>ımor</u>	e Sti	eet	Location -	LT1	Town, State	\dashv
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Balt permit Departu Import injury		f. l	· Que	Rett	in 1	1014	43	Alterr	ativ	es 8	717	Gree	en Pa	sti	reDr. MD Approximate Interval	4
Physician		23a. Part I. Enter	the disease, only one caus	or complicati	ons that caus	sed the deat	h. Do not ente	the mode of dy	ing, such as	s cardiac o	or respiratory	arrest, s	nock, or ne	art	Between Onset and	
/Medical		Immediate Caus		AAL	erosclerot	ic Cardio	vascular D	isease							Death	4
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- (Sequentially list		b	to (or as a co		of):								 	٦
!	ine	if any, leading to cause. Enter Ur	nderlying Caus	se c	to (or as a co	orisequence	OI).									\dashv
h1	Examine	(Disease or injur events resulting	ry that initiated in death) Las	t Due	to (or as a c	onsequence	of):									
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certific		123b. vyas decede		i ule	Live bir	h nt at time of		Fetal death		opic pregn	laricy				,	-
Box e death of the attented for us	Sic	1 Yes 2	No 9 ✔ 1	Jnknown (Unknow		5	Other (Specify								
· - > -	Physician	Part II, Other si	gnificant con	ditions co	ntributing to	death but no	t resulting in th	e underlying ca	use given ir	Part I.					to the cause of death?	- 1
P.O es that t	à										1	Yes 2	No 3	3 P r	robably 4 🗸 Unknown	
S, I	l b											Nas an	24b.	Were	autopsy findings available o completion of cause of	le
cords, law require has been si	=										`	autopsy performed		death	?	
Records, The law requir ficate has been s, page 2 should 1	Completed											es 2	No	1 🗸	Yes 2 No	_
	B B	25. Was case re	eferred to med		pital:				Place of De Other		sing Home	Bor	sidence 6	Ott	her.	_
of Vital ng Physician: After this certif	1 2	1 🗸 Yes	2 No	HOS	' '		✓ ER/Outpat 28b. Time		. Injury at V				injury occu	Lagrand	101.	_
of ing Pl After funera	'	27. Manner of D			28a Date of (Month,	ot Injury Day,Year)	28b. Time		Yes 2		204: 500		,,			
ion tendi eath for:	1 5	1 Natural 2 Accider	•	ending nvestigation							1006 1 000	ion /Stro	et and Nun	ober or	Rural Route Number, Cit	tv
Division tal or Attendi rs after death al Director:	1	3 Suicide	6 0	could not be	28e. Place	of Injury - A	t home, farm,	street, factory, c	ffice buildin	g, etc.		wn, State		Dei Oi	Naia Node Names, s.	.,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certif	Cortification.	4 Homici	de	letermined	(Specify)											_
Hos 24 hc Fum			Certifyin	g Physician	: To the best	of my know	ledge, death o	ccurred at the ti tigation, in my c	me, date an pinion, deat	id place, ai th occurred	nd due to the d at the time,	date and	s) and manr d place, and	d due to	the cause(s)	
To the Hos within 24 h To the Fur	legipo	one) 2		a	nd manner st	ated	Tandroi invoc		icense nun						Month, Day, Year)	_
	1 3	29b. Signature	and title of ce	rtifier		000							January :			
		tota	سالان	en. /	-18	Hel	- m		O.C.M.E.							
J.			address of pe		mpleted caus	e of death (I	tem 23a)	- 444.5	an Ctract	Raltim	ore MD	21201				
H		Patricia	Aronica-Po	ollak MD.		100	al Examine	r 111 Pe	n Street	, paitim	ore, MD 2	.1201				_
	Sta	te 31. Date filed (Month, Day, Y	ear) 6 20	07 4	strar's Sig	L	berle								
Reg	istr	ar	JAN S	2 6 20	01	Galler	9	1								
DUMU 17 Day	1/200	11			-		ORIG	INAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month U:30 AM **Physician** 200 Jan /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N memor MICE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Min. Days 1⊠M 2□F 510-466 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machtal Examiner must he notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 des 2 No ma. Director thmore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22nd St E Spouso toind. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 Removal from State Cem 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service icens Becch. FA med 12 M. Ceullall llec tana 23a. Part1. Enter the divides, or complications that caused the death. Do not enter the mode of hing, such as cardiac or respiratory arrest, shock, or heart filters. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician year! Mehasmatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, transcriptions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 □ Yes 2 □ No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renn 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 page this certificate 1□ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3□ DOA မ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After ormuletely filled in by the funeral (Month, Day Year) Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Box 68760, P.O. or Vital Records, Division

17

DHMH 17 Rev 1/2001

State Registrar

STANCE Wo 31. Date filed (Month, Day, Year

29b. Signature and title of certification

M.D. 3333 NO. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

29d. Date signed (Month, Day, Year)

07-00499 Jhani

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jhaniyah Davis		State of Maryland / Departme For State Certifica egistrar Certifica	ent of Health and ate of Death	Mental Hyg	iene Reg.	No. 200	7 0200
Physician	1/	Decedent's Name (First, Middle,Last)			Date of Death Month D	ay Year	3. Time of Death
Medical Examina		Jhaniyah Imani Davis a Facility Name (if not institution, give street and number)	4b. City, Town, or Lo		lanuary 18,	2007 4c. County of Deat	1330 hrs
	ı	3407 Philadelphia Road	Abingdon	cation of Death		Harford	,
Funeral Director		2. Social Security Number 6. Sex 7. Age (In yrs. last birth 1. 1 M 2 X F 2. Javal Residence of Decedent	Months Days Yrs 9	Hours Min.	Date of Birth(MM/DD/YYYY) 9. Bi Forei 5. 2006	
/ any		Oa. State 10b. County 10c. City, Town	or Location				10d Inside City Limits
land f show	į	Maryland Harford Abingdo					1 Yes 2 XNo
ith the Maryland 23a or 28a-f show notified at once.	Director	0e Street and Number 3407 Philadelphia Road	10f. Zip Code 21009			Citizen of What Cou	intry?
	– L	Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, N				rican Indian, Black,
er deat		X Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No s		an, 0.0.7		7-
urs aft toral"	<u>a</u>	15. Decedent's Education (Specify only highest grade completed) 16a. [Decedent's Usual Occupation	(Give kind of work		Specify: B] Sb. Kind of Business	ack Industry
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death want of Health and Mental Hygiene. It: If iten 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	luring most of working life. D	O NOT use retired)			
5-003 led within tygiene. other th	틹	7. Father's Name (First, Middle, Last)	18	.Mother's Name (Fi	rst, Middle, Maid	den Surname)	
ore, MD 21215-0036 as 1 and 2 should be filed within 7 left and the filed within 7 left and 1 should be filed within 7 left and 2 should be filed within 1 left and 2 should be filed with 1 left and 1 left and 2 should be filed with 1 left and 2	8	Saheed Bayete Davis				it Shropsh	ire
ore, MD 2121. Stand 2 should be fit of Health and Mental I of Health and Mental I is marked ner traumatic event,	2	-1	. Mailing Address (Street a	ind Number or Rura	I Route Numbe	r, City or Town, State	e, Zip Code)
and 2 fealth a ten 2 ten 2 ten 2 traum		Oa. Method of Disposition 20b. Place o	0 Rock Glenn f Disposition (Name of ceme	Havre d	e Grace	. Marylar	<u>d 21009</u> Town, State
nore ages 1 ant of F at: If i		Darial 2 Ordination 5 Itemovariion otate	ory or other place)	73 1 07	07		
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	ł	4 Donation 5 Other Specify. H19NV1 1. atu of F eral Se ice ensee	ew Memorial (ineral Ho	me. P.A	allston,	Marvland
	4	will my	1317 Cokes	sbury Roa	d, Abin	qdon, Mar	yland 21009
Physician /Medical	1	3a. Part I. Enter the disease, or a solic flons that caused the death. Do no failure. List only one cause on each line.		ich as cardiac or re	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
Examiner		mmediate Cause (Final disease or condition resulting in death) a. Smoke Inhalation and Therm Due to (or as a consequence of):	iai injuries				Death
		Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):					-
	S۱	cause Enter Underlying Cause Disease or injury that initiated					
ansit ansit	EX	events resulting in death) Last Due to (or as a consequence of):					
50, to be executed to yisician and is burial - transit	Medical	UNPENDED					
760 ficate b g physi the bu	ě	FFEMALE: 3b. Was decedent pregnant in the		1-		23d. Date of deliver	,
Sox 6876(death certificate e attending phys	Clar	past 12 months? 2 4 Pregnant at time of death 5		Ectopic pregnancy		Month	Day Year
Bo he deat the deat the deat for hed for	Pnysician	Yes 2 V No 9 Unknown 9 Unknown					
, P.O. E res that the d signed by the be detached	6	art II. Other significant conditions contributing to death but not resulting	in the underlying cause give	en in Part I:		cco use contribute to	the cause of death? bably 4 Unknown
cords, law require has been si	Completed				24a. Was an		utopsy findings available
ecol ne law te has	틸				autopsy performe 1 Yes 2	d? death?	completion of cause of
Vital Recysician: The his certificate director, page	3 8	5. Was case referred to medical	26.Place of	Death (Check only	-	No 1 Y	es 2 No
of Vit	<u>ا</u> ⊵	1 Tes 2 140	Apation C Box	her Nursing H		sidence 6 🗸 Othe	r Scene
on of \nding Phy th r: After th e funeral		77. Manner of Death 28a Date of Injury 28b. T 1 Natural 5 Pending Jan 18, 2007 1022	ime of Injury 28c. Injury a			injury occurred ed in house fire	
IVISION or Attendather death Director:	IIcat	2 V Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, fa		haasf	Location (Stre	et and Number or Ri	ural Route Number, City
Division ppital or Attencours after death leral Director: filled in by the	Certification:	4 Homicide determined (Specify) Single Family		340	or Town, State 17 Philadelphi	e) a Road, Abingdor	ı, M D
	edical	9a. Certifier 1 Certifying Physician: To the best of my knowledge, dea check only 2 Medical Examiner: On the basis of examination and/or in and manner stated	vestigation, in my opinion, d	eath occurred at the			
		Melina Massell, MD	29c. License r O.C.M.			anuary 19, 200	
1		Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD	111 Penn Street, Bal	timore, MD 21			
Star	~	1 Date filed (Month, Day, Year) 32. Redistrar's Signature	Analla				
Registra	_	JAN 2 6 20071 Stages St	AND THE SECOND S				

			1 - For State Registrar	State	of Marylar		artmen <i>tificat</i>			and M		jienez eg. No.	007	02010	
	Physicia	20	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death	
	/Medic		Mary Elliott								JANUAR:		200	7 12:30 AM	
>	Examin	er	4a. Facility Name (If not institution	-			4b. City,		Location o			4c. Co	ounty of Dea	th	
			Union Memori 5. Social Security Number	al Hospit	7. Age (In yrs.	In a t-historia - A	If I Inder	1 Year	1timo		O Date of Right	<u> </u>			
	Funeral Director		060-18-5700	1 □ M 2 🏋 F	7. Age (m y/s.		Months	Days	Hours	Min.	8. Date of Birth (Month, Day Nov 19,	Year)) Ne	thplace (State or Foreign ountry) W York	
			Usual Residence of Decedent		00						100 103	1720	110	10110	-
	ehow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				-			10d. Inside City Limits	
3	Maria de Maria	cto	MD			Baltimo	ore							1X Yes 2 No	
4	or 28	Ore.	10e. Street and Number				10f. Zip		1006			0g. Citize	n of What Co	ountry?	
	230	Funeral Director	6100 Everwall						1206				USA		
4	Items Items	nue	11. Marital Status	Armed F		J.S. 13.	Was Deced f Yes, spec	dent of His cify Cubar	spanic Orig n, Mexican	gin? (Spe 1, Puerto l	cify Yes or No- Rican, etc.)	14	Race - Ame Black, Whit	erican Indian, te, etc.	
9	l', or	by F	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	led I ∐ Yes If Yes, G Year or I	2∭No Sive Dates:		1 🗆 Yes	2 ∑ No	Specify:			S	pecity: wh	ite	
3	ature	ed	15. Deceden	t's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind	of Business	/Industry	
ו ב	Ned in	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed,	(1-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired,	luring most)	t of workir	ng				
7	giene pr the	mo:	12	0	(1-401 5+)	h	ousev	vife				OW	n home	2	
3	al Hys	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,				_
9	Ments Ments arked	ToE	Anthony Di	lck						Ther	resa Pri	ıhnia	k		
ם כ	z should be filed within 72 hours after deeth with the Maryland 1 and Mental Hygiene. 1e marked other then "neturel", or Itema 23a or 28a-f show raumatic event, the Madical Examinat nutst be incitified at	Ì	19a. Informant's Name/Relations				-	•			Route Numbe				
≥ ′	and eelth m 27 her tr		Frank Dick/bro	ther	1	7328		-	treet		th High				
ָב כ	reges in nent of H ant: If Itel ary or oth		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from		Place of Dispo cemetery, crer	sition (Nar natory or c	ne of ther place	e)	D	ate	20c. Loca	tion - City or	Town, State	
	ment ment: jury		4 ☐ Donation 5 🕅 Other (S	pecity) in st	ate				İ						
	permit. Fegas 1 and 2 should be lited with the Marylat Depmit. Fegas 1 and 2 should be lited with the Marylat Depmit and Medial Hygiene. Deportant: If I term 27 is marked other then "neture!", or Itema 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar maint be notified at one.		21. Signature of Euneral Service Ronal d	1///	Wen	Ва	1time	ore.	MD 2	21201			imore	Street	
			23a. Part1 Enter the disease, or shock or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between	
y P	hysician		Immediate Cause (Final disease or condition	/	MYOCAL	R DIAI	Ir	FAR	CTI	24/				Onset and Death	
,it	/Medical		resulting in death)	Due to	M YO CA I	quence of):		1 717	(0)					201173	-
,	Examiner		Sequentially list conditions.	b(CORON O (or as a consec	ARY	AR	TER	Y L	DISE	ASE			10 YEARS	
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):									
	and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a consec	quence of):									_
, 00,	oe ey ician buria	a E		l Due to	7 (0) 43 4 00/1360	querice or).									
00	phys s the	dicai		d											-
X	ding re as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregn	ancy						224	d. Date of de	livon	
֝֞֟֝֟֝֟֝֟֝	atter for u	ciar	in the past 12 months?	1 Live	birth 2 Feta	al death 3 □	Ectopic pr Other (sp					230	Month .	Day Year	
j į	me o	nysi	9 Unknown	9□ Unkr											
L	s mar		Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use	contribute to	o the cause of death?	
cords,	quire on sig uld b	Pa Pa	HYPERTEI	USION							1 🗆 Y	es 2 🗆 I	No 3□P	robably 4 Donknown	
2	aw re	bet									24a. Was a	ın a	24b. Were a	utopsy findings available	
ב ב	te he	Completed by				-		-			autop: perfor	med?	prior to death? 1 ☐ Yes	utopsy findings available completion of cause of	
VIII I	Stor. F	0	25. Was case referred to medical						26. Place	of Death	(Check only or		1 103	2 2 10	-
>	nysic nis ce direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	t 3 DC	Othe	r: 4 □ Nui	rsing Hon	ne 5 ☐ Resid	ence 6[Other (Spe	ecify)	
) = 1	fter t		27. Manner of Death 1 ☑Natural 5 ☑ Pendin	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	2	8c. Injury Work	at	2	28d. Describe h	ow injury o	ccurred		-
2	endil eath. or: A the fu	cati	2 Accident investig	gation			М		/es 2 □ l	No					
IO HOISINIC	fler d fler d jrect n by 1	Certification:	3 ☐ Suicide 6 ☐ Could a determine	ined 286. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, str ify)	eet, factory	, office		2	28f. Location (S City or Tow	treet and f n, State)	√umber or R	ural Route Number.	
. ב	urs a urs a aral E		20-0-11												
:	To the Hospital of Attending Physician: The law requires that the death certificate be executed within the Abours attended. To the Funerial Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To th Examiner: On the l	ne best of my kni basis of examina nner stated.	owledge, deatl ation and/or in	occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, a th occurre	and due to the c ad at the time, d	ause(s) ar late and pi	id manner as ace, and du	s stated. e to the cause(s)	
	o the o the omple	Med					290	. License	number			9d, Date	signed (Mon	th, Day, Year)	
) '	- ≯ ⊢ ŏ		V maila	noxim	tra m	2.0		AT	2412	201	11	7		,,	
•			30. Name and address of person	who completed car	ise of death (Ite	m 23a) (Type	Print) -	111	273	07	16000	FRY	ARY	, 200 /	_
			Union ME	MOKIAI	HOSP	1 TAL.	201	Dai	UEKS	517Y	PKUNU	RA	1 DMA	th, Day, Year) 7, 2007 \D KE MD 21218	>
	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature And	alls &	_ ,,,,	5 5 100		7,101	211	C(1/10/	W 1-10 0.210	-
	Registr	ar	IAN 2 6	2007	Status of	I. Ville	to Call Control								

			Please	Type or Print									1 1
			For State	State of Ma	rylari			ite of E		vientai i i	Reg. No	Z U U I	02011
			Registrer 1. Decedent's Name (First, Middle, Las	it)			Tillica	ie oi L	- Catiri	2. Date of D).	3. Time of Death
	Physicia			person						Month	2	y Year 2007	67:28 AM
	/Medic Examin		4a. Facility Name (If not institution, give		· · ·		4b. City	y, Town, or	Location of Deat			. County of Death	
	LAGIIIII	•	Franklin Sauce	ure. Hos	01+	al		Kas	edale			Balti	more
	Funeral		5. Social Security Number 6. S	ox 7. Age □M 2☑F		last birthday Yrs.	Months	er 1 Year s Days	If Under 24 Hrs Hours Min.	8. Date of 8 (Month, D 11/08/	irth ay, Year 1011	9. Birth	place (State or Foreign Intry) Land
	Director		218-42-0962 Usual Residence of Decedent	- 4	62	Ζ 113.				11/00/	1233	riar y	Tana
	yland	1	10a. State 10b. County			y, Town or I							10d. Inside City Limits
	a-f e	cto	Maryland Baltimo	re	Dui	ndalk					,		1 ☐ Yes 2X No
4	or 28	Funeral Director	10e. Street and Number					Zip Code			_	itizen of What Cou	untry?
	• 23a	ral	701 Aldworth Road	12. Was Decedent E	voc in II	C 12		21222	spanic Origin? (5	Specify Yes or N	U.S	14. Race - Amer	ican Indian.
te e	itam Itam	nu-	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		.3.			spanic Origin? (S n, Mexican, Puer	to Rican, etc.)		Black, White	
→ 036	be tiled within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel; or iteme 23a or 28e-f ehow event. Ital Medical Examination must be notified at	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 XNo	Specify:			Specify: W	nite
-\0- -	72 ho	Be Completed	15. Decedent's Ed (Specify only highest gra	fucation de completed)		16a. Dec (Giv	edent's Us ve kind of w	vork done d	ition fu <i>ring</i> most of wo	rking	16b. l	Kind of Business/I	ndustry
2121	c * M	d L	Elementary/Secondary (0-12)	College (1-4or 5	+)		. bo wor ofilm)		Mc	edical	
	filed v Hygie other t	ပိ	12 17. Father's Name (First, Middle, Last)			MICI	OTTI	leT_	18. Mother's Na	me (First, Midd			
	should be filed within of Mental Hygiene. marked other then imatic event.	To Be	Raymond Cox						Anna Ca	arter			
Maryland	shou and M a mar umat	-	19a. Informant's Name/Relationship (Type, Print)			•				-	or Town, State, Z	
	and 2 selth in 27 i		Ruth Ann Crisp (D	aughter)	1				Road, Ba		· · · · · · · · · · · · · · · · · · ·	aryland 2	
altimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: if Item 27 is marked any injury or other traumatic ex		20a. Method of Disposition ↑ Burial 2 ☐ Cremation 3 ☐		0	Place of Discemetery, cr	rematory or	r other place	01/	Date		Location - City or I	Maryland
Ø.₽	t. Partmen		4 Donation 5 Other (Specif		НОТ				rd. 01/				
B / /B	Departiment of the particular in the particular		21. Signature of Funer I Service Licer	1586			1/07	Ald E	uzdzins. 'astern	ki Fune: Nyanua	rai I Essa	Home, P.A	A. Land 21221
		(23a. Part1 Emarthe disease, or com shock or heart failure. List only	plications that caused	the deat							Jan, Hary	Approximate Interval Between
	Physician		shoot or heart failure. List only Immediate Cause (Final disease or condition	One cause on each line	e.	VALAR	-hali	inn X	shetri	ictive 1		dispose	Onset and Death
	/Medical		resulting in death)	Due to (or as a	conseq	uence of):	DOCT	1011 0	1 0105110	active i	W G	41Jeuse	114 160
	Examiner		Sequentially list conditions.	. Chroni	ic c)bstr	ucti	ve 1	ing di	sease			15 years
S	si ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a conseq	juence of):							·
10	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	conseq	uence of):							
260	e be e	8		d									
Box 687	Physician: The law requires that the death certificate in this certificate has been signed by the attending physicat director, page 2 should be detached for use as the t	Completed by Physician/Medic											
Š	th cer tendir ir use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of			3 □Ectopic	pregnancy				23d. Date of deli Month	very Day Year
	e dea the at hed fo	sici	1 Yes 2 No	4□Pregnant at : 9□Unknown	time of d	leath !	5 Other ((specify)			.		51 ,
P.0	that the de	Ph	Part II. Other significant conditions	contributing to death bu	ut not res	ulting in the	underlying	g cause give	en in Part I.	23e. Dio	i tobacco	use contribute to	the cause of death?
ds,	uires l signe	d by	Hypertensian C	oronary a	urter	y di	sease	2		1 5	Yes :	2□No 3□Pr	obabiy 4 Unknown
Sor	w requir been si should	lete	1	1						24a. W		24b. Were au	topsy findings available
Re	he law e has age 2	ф								au pe 1 ☐ Yes	topsy normed? 2 2 N	death?	completion of cause of 2 □ No
ta	sician: The la certificate ha irector, page 2	0	25. Was case referred to medical						26. Place of De	eath_(Check only			
<u></u>	Physicia this cert at direct	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpat	tient 3 🗆 I		4 Nursing			6 ☐Other (Spec	city)
0	fte in a		27. Magner of Death 1√□ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time Injur	У	28c. Injun Wor		28d. Describ	e how inj	ury occurred	
Division of Vital Records,	death. ctor: A y the fu	Icat	2 Accident investigation 3 Suicide 6 Could not be	On Disco of Injur	ırv - At h	ome farm	M street fact	1	Yes 2 □No	28f, Location	(Street a	and Number or Ru	ral Route Number,
Div	or A efter Direc	Certification:	4 ☐ Homicide determined	building, etc	. (Speci	fy)	3(100), 140	iory, omico			own, Sta		
	To the Hospital or Attending within 24 hours efter death. To the Funeral Diractor: After completely filled in by the funer		29a. Certifier 1 ☐ Certifying P	hysicien: To the best of	of my kno	owledge, de	ath occurre	ed at the tin	ne, date and place	e, and due to the	e cause(s) and manner as	stated.
	he Ho in 24 I he Fu pletel	Medical	one)	miner: On the basis of and manner sta	examina ited.	ation and/or				urred at the tim			
	To t To t	Σ	29b. Signature and title of certifier	1			2	29c. Licens	e number	000	290/0	ate signed (Monti	n, Day, Year)
			mu just	4.9.		as : =		70	300C	00	123	101	
	m		30. Name and address of person who	completed cause of de	eath (Iter	m 23a) (Typ	De, Print)	nVlir	Sana	ro Driv	ve	Po Ho	ND 21237
	Sta	ite	31. Date filed (Month, Day, Year)	3. Registra	ar's Sign	ature	1 104	r 19	- Luck	, , 1	-	CHILLY.	1 2 2 2 7
	Registr		IANO C 200	7 Barre	,		SHE!						

07-00559 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Raephael Evans State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 20, 2007 **Medical Examiner** RAEPHAEL EVANS 2141 hrs 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Maryland General Hospital N/A 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYXX) 9. Birthplace (State or **Funeral** 214-54-1439 Months Days Hours Director 1 X M Country)MARYLAND 2 9-22-1950 56 Usual Residence of Decedent 10b. County 10a State 10c City, Town or Location 10d Inside City Limits MD. N/A BALTIMORE 1 X Yes 2 No 28a-f show Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 501 DOLPHIN ST. APT 508 21217 USA Funeral Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes Give Year 3 Widowed Divorced 1 Yes 2 X No specify. Specify BLACK þ 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) and 2 should be filed within 72 l is marked other than tic event, the Medical MD 21215-0036 -7--0-LABORER CONSTRUCTION and Mental Hygiene 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be LESTER J. EVANS VIRGINIA WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 19a. Informant's Name/Relationship (Type, Print) 2 item 27 is ır r traumatic 1027 CATHEDRAL ST. APT 15M BALTIMORE, MARYLAND VIRGINIA EVANS (MOTHER) Baltimore, 20a Method of Di 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State X Cremation crematory or other place) 1 Burial Pages 1 Removal from State mportant: METRO CREMATORY 1-25-2007 4 Donati BALTIMORE, MARYLAND Other Specify HIB New Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. XT/AN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical a Hypertensive atheosclerotic cardiovascular disease Immediate Cause (Final disease Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED #23a,PII,27,perME, g863 1/31/07 TT The law requires that the death certificate be Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o þ Diabetes Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records. 24a Was an autopsy has performed? death? certificate 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 ٥ DOA 1 🗸 Yes After 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification:

To the Hospital or Attending Physician: To the Funeral Director:

24b. Were autopsy findings available prior to completion of cause of 2 No 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be

Death

January 21, 2007

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

O.C.M.E

200

Year)

determined

Homicide

30 Name and address of

se of death (Item 23a) rson who completed Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Voar 5:47 AM 23 <u>Elvin</u> Fields January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. Sina; Hospital of Baltimere 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1**X**]M 2□F Yrs. Director 215-60-5508 54 12/31/1952 North Carolina Usual Residence of Decedent within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TyYes 2 □ No Funeral Director Maryland Raltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or Items 23a or Examiner must be r 4819 Palmer Avenue U.S<u>.A.</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked or Clara Hawkins Nathaniel Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nathan Fields / Brother 717 Carroll Street, Baltimore, Maryland 21230

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/26/2007 Baltimore, Maryland 22 Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Castrointestinal /Medical Due to (or as a consequence of): Examiner Gastric Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transil Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mallifus Completed Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autonsv performed2 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59062 January 23, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W Belvedera Baltimore 21215 Chad Hansen, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 6 Registrar 2007 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6:25 A Mark Alan Fitzpatrick 2007 24. /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**√**M 2□F Months Director 052-60-7389 June 25, 1961 New York Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Succession of Su 1111 Henderson Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 27 Married 1 ☐ Yes 2√2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Assistant Plant Manager Bleach Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laurence Laverne Fitzpatrick Anna Cecelia Baran ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: if Itam 27 is
any injury or other trau 1111 Henderson Road, Bel Air, Maryland 21014
of Disposition (Name of Dis Shirl Fitzpatrick / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-3-07 Town of Ellicott, NY Mt. Olivet Cemetery 21. Signature of Funeful Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** germ cell cancer 7 months metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 2 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2' No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 1 Yes 2 No Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\triangle \text{Other} \((Specify) \) ပ္ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Myo Min

31. Date filed (Month, Day, Year)

JAN 2 6 2007

DHMH 17 Rev 1/2001

10

M.D. 602 South.

. Registrar's Signature

Atwood Rd, #200 Beldir, mo

		•	For State Registrar	State	of Maryla	•	artment of F		Mental Hy	/giene Reg. No	7111	7	020	15
			1. Decedent's Name (First, Middle	, Last)					2. Date of D		٧		3. Time of De	eath
	Physici		Maudie	Bert	Tidwe	e 11	Gillikin		Janua	ry 1	, 20°C	ear 7	12:53	М
2	/Medic Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, o	r Location of Deat	th	40	. County of I	Death		
		•	Manor Care Nur	sing Hom	e		Chevy C	hase		M	ontgom	nery	,	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth	9.	. Birthpl	lace (State or F	-oreign
	Director		290-01-5541	1 □ M 2 🖾 F	9	3 Yrs.	Months Days	HOUIS MIII	08/24/	1913	3	SC	17 y)	
	P .		Usual Residence of Decedent											
	unylar show		10a. State 10b. County		100.	City, Town or Lo	cation					10	0d. Inside City	
	Ba-f.	ct	MD Montg	omery	c	hevy Ch	ase						1 Yes 2	MINO
	다 15 0 c 26	Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of Wha	at Coun	try?	
	deeth with the Maryland ma 23a or 28a-f ahow rimust be routified at	- La	8700 Jones Mil	1 Road			20815			Į	JSA			
	de ma	Funeral	11. Marital Status	12. Was Dec Armed F	cedent Ever in orces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race Black, \	America White, e		
õ	within 72 hours after ene. than "natural", or ite		1 Never Married 2 Marr	If Yes, G	2X No iive		1 ☐ Yes 2⊠ No	Specify:		i	Specify:	Wh	ite	
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land	ntal h	Be	Floyd M. Tidw	-					Mae Li					
ج	d Me d Me mark matic	ဥ	19a. Informant's Name/Relations			10h Maili	ng Address (Street					ato Zin	Codol	
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<u>ရ</u>	1 and Heefi am 2 ther		Sue Woods/Niec	e	20b	Place of Disno	sition /Name of	-1	Date		ocation - Cit			_
E E	ages nt of nt of if it		1 ⊠ Burial 2 □ Cremation		n State W	cemetery, cres estview	matory or other plac Memorial etery	(9)	127/07					
	rtant rtant		4 ☐ Donatten 5 ☐ Other (S) 21. Signature of Funeral Service		P	ark Cem	etery 2. Name and Addre	I I	/27/07	Har	tsvil	le,	SC FIL	
a	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinat must be notified at anone.		21. Signature of Fulleral Service	111			306 West							
			23a. Part1. Enter the disease, or	complications that									Approximate	
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.				to or respiratory	a1103t,			Interval Betwe Onset and De	en ath
}	Physician /Medical		disease or condition resulting in death)		dvar		Rmen	ha.				_		
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		-	Sequentially list conditions,	b. — Down	(or as a cons	expense off:								
/	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(3. 20 2 00	-4-500 0.,.								
_	be executiclen and burial-tran	xar	that initiated events resulting in death) Last	c. Due to	o (or as a cons	equence of):								_
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200	death certificate ie attending phys ad for use as the	edical		d								_		
Š	leath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pred	nancy					23d. Date o	of delive	NOV.	
Ď	atter for L	ciar	in the past 12 months?		birth 2 ☐ Fe mant at time o		Ectopic pregnancy Other (specify)	,			Month		Day Yea	ar
j	the d y the tched	Physician/M	1 □ Yes 2 No 9 □ Unknown	9□ Unk				20-01-11						
7	thet ed b deta		Part II. Other significant condition	ns contributing to	death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribu	ute to th	e cause of dea	ith?
as,	requires een sign hould be	d by							1 [Yes 2	!□No 3[☐ Proba	ably 4 ⊈% ini	known
cord		Completed							24a. Wa	s an	24h Wei	re autor	ney findings av	alabla
ě	sician: The law s certificate has b irector, pege 2 st	ם							aut	opsy formed?	prio dea	r to con	psy findings ava npletion of cau	se ot
ā	n: Th ficate r, pe		00 111						1 ☐ Yes	2 N		Yes	2,No	
VII	Physician: rthis certific ral director,	Be c	25. Was case referred to medical examiner?	Hospital:		F1.55/2	oth		ath Check only					
Ö	Physral di	2	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	IL 3LI DOA	4 Mursing i	Home 5 Res				')	
5	ding P. After fune	Į.	1 ØNatural 5 ☐ Pendin	g (Mo.	nth, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 200020	r now in the	ny occurred			
S	deat deat ctor: y the	fica	3 Suicide 6 Could i	not be Die	e of tniury - At	home farm str	reet, factory, office		28t. Location	(Street a	nd Number	or Rura	l Route Numbe	ar
UIVISION	el or Attending F s after death. il Director: After id in by the funeri	Certification;	4 ☐ Hornicide determ	build	ding, etc. (Spe	icify)	cot, ractory, omco		City or To			J. 11514.		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		2ia Cartifier (Cartifyin	g Physician: To th	na bast of my k	nowladge: deat	occurred at the tir	ns, date and place	a and due to the	o daunale	and make	of an et	aled.	
	24 h 24 h Fui etely	edicai	(Check only 2 Medical one)	Examiner: On the	basis of exami nner stated.	ination and/or in	vestigation, in my o	pinion, death occ	urred at the time	, date an	d place, and	due to	the cause(s)	
	omp	Me	29b. Signature and title of certifie	2			29c. Licens	e number		29d. Da	ate signed (A	Month, (Day, Year)	
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	10		30. Name and address of person	who completed car	use of death (It	tem 23a) (Type.	Print)	-1706	,	. 1				
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	Sta	te	31. Date tiled (Month, Day, Year)	32.	Registrar's Sig	nature		10,1		, 10				-16
	Registi	ar	JAN 2	6 2007	Partie Said	1. A	Print) Print) Print R							

07-00653 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Donna Jean Godfrey State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Month Day January 23, 2007 Medical Examiner Donna Jean Godfrey 1401 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death E/B 14700 Baden Navlor Road Croom Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign DC Country)Washington Davs Director 578 56 3192 63 July 11, 1943 1 M 2 X Usual Residence of Decedent 10b. County 10c. City, Town or Location any 10d. Inside City Limits 23a or 28a-f show notified at once. 1 Yes 2 X No Maryland Prince George Upper Marlboro hours after death with the Maryland 10e Street and Number Direct 10f. Zip Code 10g Citizen of What Country? 15401 Candy Hill Road 20772 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 X Married Yes 2 X X No If Yes, Give Year Divorced Widowed 1 Yes 2 XXNo specify: Specify White þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) within 72 | is marked other than ' Baltimore, MD 21215-0036 12 Adm. Asst. Law Enforcement 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Othell C. Blue Roland Lee Heath 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 James E. Godfrey (Husband) 15401 Candy Hill Road, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery 29 20a. Method of Disposition 20c. Location - City or Town, State 2007 or other 1 X Burial 2 Cremation 3 Removal from State Department o Clinton, MD Other Specify: Donation 5 Mary Piscataway (lemetery 22. Name and Address of FacilityLee Funeral home,Inc Signature of Fundral Service Licensee 6633 01d Hans mov251 Alexandria Ferry Road, Clinton. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate by 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknowr Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed? Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ ER/Outpatient 3 Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Jan 23, 2007 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: Driver auto fixed object collision Natural 1332 hrs Pending Yes 2 V No 24 hours after death Funeral Director: filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
E/B 14700 Baden Navlor Road , Croom, MD (Specify) Local Street Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only within ? one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 24, 2007 and address of person who completed cause of death (Item 23a)

Registrar

State

Pamela E. Southall, MD

IAN

31 Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32 Registrar's Signature

Eric Tyrone Gray		State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death		. 0007 0001
Physicia	n/	1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death	3. Time of Death
Medical Examir	ner	tric lyrone Gray	Month D January 23,	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8770 Tamar Drive Columbia		4c. County of Death Howard
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	— • • •	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		214-1343+8 1XM 2 F 33 Yrs.	10/04/	1973 Country) MD
any .	\mathbf{I}	Usual Residence of Decedent 10a. State 10b. County 10c. City_Town or Location		10d Inside City Limits
and show:	5	MD Howard Columbia		1 Yes 2 No
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	10e. Street and Number 10f. Zip Code	10g	Citizen of What Country?
with th	冒	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14 Race - American Indian, Black,
r death with the or items 23a must be noti	nue	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.
hours after natural", c		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of w	undi dana Ida	Specify: Slack
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)		6b. Kind of Business/Industry
0036 within ene er than	Completed by	Ayrs Clerk		Food Services
21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural", e event, the Medical Examiner	Be Co		(First, Middle, Mai	den Surname)
ID 2121 should be f and Mental 7 is marked natic event,				er, City or Town, State, Zip Code)
ore, MD :s. 1 and 2 shot of Health and If item 27 is ner traumatic		Michael T. Gray (Father) 6 Crooked Willow (20a. Method of Disposition (Name of cemetery.)	t., Cator	
Baltimore, MD 21215-0036 oemit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", nijury or other traumatic event, the Medical Examiner		1 Burial 2 Cremation 3 Removal from State crematory or other place		Oc. Location - City or Town, State
Baltimore permit Pages I Department of Important: of injury or other	ı	4 Donation 5 Other Specify: Sarrison Furest 01/ gnature of Finites e Lines e 22 True and ordress of facility or	31/2007	ne Services
	1	Vicus my view 5151 Batto. Nati &	ike Bab	hmore, MD 21229
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respira ory arrest.	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. HangIng Due to (or as a consequence of):		Death
No. 1	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated		
		events resulting in death) Last Due to (or as a consequence of).		
60, e be evecuted ysician and burial - transi	Physician/Medical	UNPENDED AMENDED		
	Me	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	IDCV	23d. Date of delivery Month Day Year
Box 687	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	oy	Month Day Teal
cords, P.O. Box 6876 law requires that the death certifica has been signed by the attending ph 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e Did toba	cco use contribute to the cause of death?
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tal Recian: The	BeC	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Outnatient 3 DOA Other Nursing	only one)	
of Vi	음	1 V Yes 2 No I I I I I I I I I I I I I I I I I I	g Home 5 Re 28d. Describe hov	sidence 6 Other: Scene
Division of Vital Records, P.O ral or Attending Physician: The law requires that trs after death "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Certification	1 Natural 5 Pending FO ^(Month) PO ^{(Month}	Subject hange	
ivisi or Att after de Direct		28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stre	eet and Number or Rural Route Number, City
Ospital hours uneral y filled		00- 0-46		e) ve, Columbia, MD
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cause(s it the time, date and	s) and manner as stated. d place, and due to the cause(s)
To wish	Ř	and manner stated. 29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month, Day, Year)
		Josho Deef MD O.C.M.E.		January 24, 2007
V		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, ME	21201	
Sta	ate	31. Date filed (Month Day, Year) 32. Registrar's Signature		
Regist	rar	JAN 2 6 2007 Regione M. Joseph 5		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Daisy Adeline Garland 01 25 2007 6:23 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air 1 Year Harford If Under 24 Hrs. last birthday) Birthplace (State or Foreign Country) Security Number 8. Date of Birth (Month, Day, Year) Months Days Min. 1 □ M 2 🔯 F Hours Maryland 06/23/1919 216-14-2003 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Harford Street 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 726 Cherry Hill Road Funeral 21154 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Secretary Baltimore Orioles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Henry Penn Edith Jane Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James W. Garland (son)</u> 726 Cherry Hill Road - Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Camp Chapel Ch. Cem. 01/27/2007 | Perry Hall, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6 aseadn 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chemic obstence Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Was an autopsy performed?

Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner P.O. Box 68760, ોતોડ∖ુ કિલ્દ Ωિખલી Division or Vital Records,

physician and the burial-tran signed by After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

Funeral

Director

filed within 72 hours after

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Pages 1

Physician

/Medical

1/2.5/07 04.23 altimore, Maryland 21215-0036

Certification:

29a. Certifier (Check only one)

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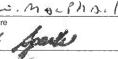
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID 31. Date filed (Month, Day, Year)

JAN 2 6

29b. Signature and title of certifier

615 W. MOL 32 Registrar's Signature

and manner stated.



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D3225

29d, Date signed (Month, Day, Year)

JAMUD Cy 25

Baloir ma

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

voums

Thomas V. Joseph, M.D.

Jump

D004733 D

50 West Edmonston Drive, #207, Rockville, Maryland 20852

January 25, 2007

	1 - For State Registrar		State of	viai yidili		irtment of l tificate of		nu W		giene Reg. No. 🦩	000-	7 000
	Decedent's Name	e (First, Middle,	Last)						2. Date of De	ath	111	3. Time of Dea
cian lical	Mildred	V. Go	od-Clark						Month January	Day	Year 2007	01:10
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l r	212-44-	4296	5. Sex 1 □ M 2 ▼ F	Age (In yrs. Id 61	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birl (Month, Da 2 - 0	4 – 45	9. Birt	thplace <i>(State or Fo.</i> Du <i>ntry)</i> Md
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Be	17. Father's Name ((First, Middle, La			Nu	rse	18. Mother	s Name	(First, Middle,	Maiden Sui	rname)	
To B	Joseph	Green	e				Odia	a Ne	esbitt			
-	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mailin	g Address (Stree	t and Number	or Rura	l Route Numbe	er, City or To	own, State, 2	Zip Code) 212
	Angela	P. Ham	m/Daught		340	2 Dolfi	ield A	we.	, Apt	. # 1	.05,	Balto. N
	20a. Method of Disp		B □Removal from St	20b. Pl	ace of Dispos emetery, cren	sition (Name of natory or other pla	ice)		ate	20c. Locati	ion - City or	Town, State
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Certification: To Be Completed by Physician/Medical	23b. Was decedent in the past 12 1	red to medical No h 5 Pending investigat 6 Could not determine	1 ☐ Live birt 4 ☐ Pregnar 9 ☐ Unknow s contributing to deat 5 ↑ ○ P Penal C Hospital: 1 ☑ Inp 28a. Date of (Month, the ed) 28e. Place of building Physician: To the base caminer: On the basis	h 2 Fetal at at time of den n h but not resulting the fetal state of	death 3 Lath 5 L	derlying cause gi		o 2	24a. Was autor performed to the control of the cont	obacco use of the street and Non, State)	Month contribute to 3 Pr 24b. Were au prior to o death? 1 Yes 1 Other (Specourred	Day Year to the cause of death robably 4 □Unkn utopsy findings avail completion of cause 2 ☑ No city) ural Route Number,
Certification: To Be Completed by Physician/Medical	23b. Was decedent in the past 12 1	red to medical No Stage red to medical No h Counting investigat Gloculd not determine	Hospital: 12 Inp 28a. Date of (Month, tibe ed building	h 2 Fetal at at time of den n h but not resulting the fetal state of	death 3 Lath 5 L	derlying cause given by the state of the sta		o 2	24a. Was autor performent of the control of the con	obacco use of the state of the	Month contribute to lo 3 Pr 24b. Were au prior to or death? 1 Yes Courred courred d manner as ace, and due	Day Year to the cause of death robably 4 □Unkn utopsy findings avail completion of cause 2 ☑ No cify) ural Route Number, s stated.
To Be Completed by Physician/Medical	23b. Was decedent in the past 12 1	red to medical No Stage red to medical No h Counting investigat Gloculd not determine	1 ☐ Live birt 4 ☐ Pregnar 9 ☐ Unknow s contributing to deat 5 ↑ ○ P Penal C Hospital: 1 ☑ Inp 28a. Date of (Month, the ed) 28e. Place of building Physician: To the base caminer: On the basis	h 2 Fetal at at time of den n h but not resulting the fetal state of	death 3 Lath 5 L	derlying cause given by a set of a cocurred at the treestigation, in my	26. Place of the second opinion, death	place, a	24a. Was autor performent of the control of the con	obacco use of the state of the	Month contribute to lo 3 Pr 24b. Were au prior to o death? 1 Yes Courred fumber or Ru d manner as ace, and due	Day Year to the cause of death robably 4 □Unkn utopsy findings avail completion of cause 2 ☑ No city) ural Route Number,
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State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 01/23/2007 U. Hungate 11:38a James /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2810 Elliot Street Baltimore n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 507–18–8285 8. Dete of Birth (Month, Day, Year) 01/24/1923 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 □XM 2 □ F Yrs. Director 83 MO Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at NE Lancaster Lincoln 1XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3609 South 37th Street 68506 USA Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 13. Yes 2 □ No If Yes, Give Year or Dates: 1942–1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: 1942-1946 White Completed by 3 ₩idowed 4 Divorced "natural" treumatic event, I'm Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Field Engineering Engineer of Health and Mental Hygie Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Donald Hungate Claire A. Parriott ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Hungate / Daughter 2810 Elliot Street, Baltimore, MD 21224 other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State tot perr it. Pages Department of Importent: If It any injury or o Bayview Crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/24/2007 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature et Funeral Service License Charles L. Stevens Funeral Home Inc 1501 East Fort Avenue, Baltimore, MD 21230 Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Accident 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Atrial Fibrillation years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit Coronary Atherosclerotic Disease years that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Hypertension 1 Yes 2 No 3 X Probably 4 Unknown Completed Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2€ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother 1987 1990 P 1 ☐ Yes 2 ▼ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 - Homicide within 24 hours To the Funerel 1. Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartillor Medical (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 At Membay 4 On Vi Mil DS3517 January 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Armel Mendoza Tagle M.D. 301 Saint Paul Place, Professional Office Building 907, Baltimore MD 21202 31. Date filed (Month, Day, Year) State Registrar JAN 2 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 25, Month 2007 Year Harrell 3:10 A M Jean 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing | Nothing 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia 579-32-6810 1 ☐ M 2 € F 82 Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11x Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 418 Park Road 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2K Married 1 ☐ Yes 2☑ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administration Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Sherwood Shellings Carrie Ethel Bragg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon T. Harrell/Son 418 Park Road, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 29. 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 2007 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of FacilityRohert A. Rockville, Inc. 300 West Mockville, Maryland 20850 Pumphrey Funeral Home Montgomery Avenue 21. Signature of Funeral Service Licenses John P. Chaplan M00092 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Renal Failure Due to (or as a consequence of): Stage 4 Sacral Decubitus Ulcer IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1□Yes 21⊠No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2▼ No 24a, Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 4☐ Nursing Home_ 5☐ Residence 6 ☑Other (Specify) HOSpice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

the Hospital or Attending Physician: The law requires that the death certificate be executed and physician ar Division or Vital Records, P.O. Box 68760. has e 2 Director: After the in by the funeral within 24 hours aft To the Funeral DI completely filled in

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

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al Hygiene. other than

Department of Health and Mental Important: if item 27 is marked or any injury or other traumatic eve once.

Physician

Examiner

/Medical

Pages 1 and 2 should be filed within 72 hours after death

altimore, Maryland 21215-0036

Director

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Completed

Be

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Examine

by Physician/Medical

Completed

Be

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Certification:

Medical

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the tirne, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier

ynthis m Alliams, DO

29d. Date signed (Month, Day, Year) nuary 25, 2007 HO058032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams, DO 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

2007

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Cynthia M Henson Month 7:00 P 18, January 2007 /Medical 4a, Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
67 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 219-38-6826 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 67 Vrs Director Feb 12, 1939 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-1 show the Medical Examiner must be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21401 160 Brownswoods Road United States Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Harvey Hicks Rosalee Culley ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 Thomas Way Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Crystal Henson/ Daughter cortant: If itam 27 is njury or other tran 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Bestgate Memorial Park Jan 24 Burial 2 Cremation 3 Removal from State Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 permit.
Departr
Imports
any njt 21. Signature of Funeral Service 22 Name and Address of Facility Politan Chapel 1922 Forest Drive Annapolis, MD 23a. Par 1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 gly comia Houls /Medical Due lo (or as a go uence of): Examiner nullitus diabetus Sequentially list conditions, any learning to mined at cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) sician Physician/Medical the attending phy as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 1 🗌 Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 31 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of M 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funaral Diractor: A 1 ☐ Yes 2 ☐ No М 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 22, 2007 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KNNX POLIS HOLL no 2448 ANGELA 2140 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 26 2007

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #20b, 26, perFH, verbal, g863 1/26/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Mary Hendricks A 9.43 0 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea 05/18/1938 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2\ F Davs Hours Min. 218-44-0544 68 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits MD Baltimore Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8337 Kendale Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 █No Specify. Be Completed by 3 Midowed 4 Divorced Specify African American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cook Toyson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Gloria Allen P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Allen / 8338 Dendale Road; Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/26/2007 1 Burial 2 □ Cremation 3 □ Removal from State Mount Zion cemetery 01/27/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y leading to in additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Door to for equil The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): physician attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year 4☐Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be O. 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

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Mary ltimore,

> certificate funeral director, After this death.

or Attending Physiclan: within 24 hours after death To the Funeral Director: filled in by the Hospitai completely

Certification: To

Medical

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State Registrar

6

5 Pending investigation

6 ☐ Could not be

Aille

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29c. License number 1965

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMBLE 1501 ayas

32. Registrar's Signature

PATIENT KNOWN AS MALLOE T, JOHNSON Baltimore, Maryland 21215-0036

			anen	d items 17,18 p State of Maryta	er the efficiency of the control of	3 1-31-07 artment of	dealth and	Mental Hygi	iene cegic	ne.		
		•	1 - State Registrar			rtificate of			g. No.	11 02026		
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				Date of Death Month		3. Time of Death Year		
	/Medi		MAUDE THELMA						22 200			
	Examir	ner	4a. Facility Name (If not institution, give				or Location of Deat	4c. County of				
			SINAI HOSPITA 5. Social Security Number 6. Se		rs. last birthday)	BALTI If Under 1 Year	MORE CI'	8. Date of Birth		N/A 9. Birthplace (State or Foreign		
	Funeral Director			□M 2		Months Days	Hours Min.	(Month, Day, 06/26	Year)	N. CAROLINA		
	P .		Usual Residence of Decedent					00120				
	arylar	_	10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE CITY							10d. Inside City Limits 15€X7es 2 ☐ No		
	the M	ectc	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·				1/	Citizen of W	Citizen of What Country?		
	d within 72 hours after death with the Maryland Jene Ir than "natural", or items 23s or 28s-1 show Irs Medical Exercines must be crotified at	Funeral Director	2918 OAKFORD	AVENUE		10f. Zip Code	215		USA	nat Country ?		
	ms 2%	era	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	1	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No-	14. Race	- American Indian,		
9	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X o If Yes, Give				to Rican, etc.)		k, White, etc. BLACK		
21215-0036	aral,	d by	3 X Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify:	DDACK		
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d 2	a the training of the training	BeC	17. Father's Name (First, Middle, Last)	John Wesle	v Willian	16	18. Mother's Na	me (First, Middle, N	faiden Sumame	3)		
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Maryland	s 1 and 2 should Health and Men Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	ng Address (Stree	t and Number or R	ural Route Number,	City or Town, S	State, Zip Code)		
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ore	0 0 = =		20a. Method of Disposition 1x□xBurial 2 □ Cremation 3 □		•	matory or other pla				City or Town, State		
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Bal	permit. F Departme Importer any injur		21. Signature of Funeral Service Licen	X A MIT.		2. Name and Addr				HOME 21207		
			23a. Enter the disease, or compliance, or heart failure. List only of	plications that caused in						Approximate		
	Dhuaisian		hock or hear failure. List only of Immedia e Cause (Final disease or condition	ne cause on each line	1 -	h .				Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a c. ns	sequence of):	1 mgoc	nuce	Lyve	m			
	Examiner		Provident Association	C	rnet	n en	belus	U				
-	₽ ≅	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):							
18	and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cops	Multi-	jun	UM					
760,	death certificate be executed e attending physicien and of for use as the burial-transit	cai E			HATI	11000						
687	icate physi s the l	dic		d	,	عصروات						
Box (leath certificate attending phy i for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre			550		23d. Date	of delivery		
m.	death e atte d for	Cia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \(\frac{1}{2} \) No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of		⊒Ectopic pregnand ☐ Other <i>(specify)</i> _	Э у		Mon	th Day Year		
P.0	that the de led by the a detached	hys	9 🗆 Unknown	9□ Unknown								
	89 69	by F	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause g	ven in Part I.			bute to the cause of death?		
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Vis	Attandiu or death. actor: A by the fu	Hice	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, str	reet, factory, office		28f. Location (Str City or Town	eet and Numbe	or Or Rural Route Number,		
	tal or Ars efter al Dirac	Certification:		building, etc. (Spe	эспу)			Ony of Your	, Slate)			
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	To the Hospital or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the	Medi	one) 29b. Signature and title of certifier	and manner stated.			se number			(Month, Day, Year)		
	D W S		250. Signature and title of certarel	CA 21		. 1	C 1/7	28	Ja M	A M		
	12		30. Name and address of person who o	complet of cause of death (I	Item 23a) (Type,	Print) DIS	741		1/5/	0 1		
	2		MASA J	Bar w	. ~ (Type,	34 x	Ar Oru	e Place	- Jue	2309		
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	Registr	rair		/1111/1 Page -	Mar .	AND D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Ruby Virginia Janish 2007 12:03 /Medical January 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3630 Valley Terrace #B-7 Baltimore Windsor Mill If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 84 216-18-7473 Director Nov.30, 1922 Mary Tand Usual Residence of Decedent . Pages 1 and 2 should be filed within 72 hours after death with the Maryland treent of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a, State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Windsor Mill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 3630 Valley Terrace #B-7 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No þ 3 ☐ Widowed 4 ☑ Divorced "natural", Completed is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Sinclair Maude Disney 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trainonce. 3630 Valley Terrace #B-7; Windsor Mill, MD 21244 Linda D. Janish Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 1/25/2007 4 Donation | 5 Dother (Specify) Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signatule of Funeral Service License 1630 Edmondson Avenue: Catonsville. MD_21228 23a. Part1. En et the disease, or complications in the sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is only one cause on each line. Approximate Interval Between Onset and Death tie Condiovascular disease Immediate Cause (Final **Physician** Artenioscleso disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical y the attending phoche ched for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner?
1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Funeral Director: 24

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) TrimBLEHII CT Lytherville, Md 21093 31. Date filed (Month, Day, JAN 26

DHMH 17 Rev 1/2001

Medical

State Registrar

07-00475 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Norma Jean Jones 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day January 17, 2007 1330 hrs Medical Examiner Norma Jean .Iones 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 9707 Branchleigh Road # 103 Randallstown **Baltimore County** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director 2 X F 05/22/1959 Country) 425-06-9613 47 Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Baltimore Randallstown MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 9707 Branchleigh Road #103 21133 USA 11. Marital Status 12. Was Decedent Ever in U S 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, 8lack If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 XMarried 2 X No Yes 4 Divorced If Yes. Give Year 1 Yes 2 X No specify: Specify R1ack Widowed the Medical Examiner "natural", \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene ant: If item 27 is marked other than ", or other traumatic event, the Medical E Social Security Baltimore, MD 21215-0036 IT Specialist Administration 5 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucinda Stevenson Nate Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3540 Derby Shire Circle, Windsor, MD James Jones/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place)
Locust Grove
Cemetery Cremation 3 Removal from State Straight Bayou, Department of Important: 01-27-2007 Donation Other Specify 22. Name and Address of Facility Byas Funeral Home Signature / Funeral Service Line ee 21 PO Box 1480, Indianola, MS Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Metastatic bladder carcinoma complicating hypertensive Approximate Interval Physician /Medical Death cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical ing physician as the burial -X UNPENDED _g864 perME. death certificate be Box 68760. IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I. Records, P.O. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate bector, page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: ivision of Vital Be Other₄ DOA Residence 6 V Other: Scene Inpatient ER/Outpatient 3 Nursing Home 5 this ၀ 1 V Yes 28c. Injury at Work? After 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: 1 X Natural Yes 2 No 5 Pending To the Funcial Mrector: death death 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E January 18, 2007 Ou 61 30. Name and address of person who completed cause of death (Item 23a)

Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #5, perFH, 6863, 1/29/07 TT

Continue Trans. Ensure All Copies Are I Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 24,2007 James Lee Johnson 8:30 A.M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | April 1 U3, 1933 5. Social Security Numb 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F 73 234-52-598 Wyatt, W. VA. **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10h. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Director Maryland n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6511 Eastern Parkway 21214 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Installer Heating & Air Condition 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Johnson Irene Hupp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Mrs. Irene R. (nee Brocato) Johnson 6511 Eastern Parkway Baltimore, Maryland 21214 Department of Health Important: If item 27 any Injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility acceful Alternatives Funeral & Cremation Ctr., P.A 25 York Road Timonium, Maryland 21093 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one gause on each line. 23a. Part1. Enter the dist Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician JtA 1 SEAJE was /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in the sequential sequence of the sequence of th Due to for as a consequence of: Examine or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DITEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPIC 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury investigation 1 □ Yes 2 □ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

completely

DHMH 17 Rev 1/2001

State Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6-BMC. 6701 31. Date filed (Month, Day, Year)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 24, 2007

N. Charles St. Balto. Md Z120x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 16, Year January 16, 2007 **Physician** 10:10AM Johnson Andre Tyrone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Gaylord Drive Suitland If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year July 1, 1961 9. Birthplace (State or Foreign 5. Social Security Number Sex 1CAM 2□F 7. Age (In yrs. last birthday) **Funeral** Months Washington, DC 45 577-90-8422 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2/TNo Director Maryland | Prince George's Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2208 Gaylard Drive 20746 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 🖔o African Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver **PEPCO** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John E. Johnson Annie M. Tate ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Gaylord Drive Suitland, Maryland 20746 Diana Doctor-Johnson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 20 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2007 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service License 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician extension /Medical (or as a consequence of): **Examiner** Mellitin bites Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Cause (Disease or kiju. that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown sign**e**d b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes has been signed 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No page, 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica filled in within 24

Baltimore, Maryland 21215-0036

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

one)

(Check only

S. OSBORNE 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURANDA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

WPEW

29d. Date signed (Month, Day, Year)

07-00316 Arafin Kromah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Aratin Kroman		_	epartment of Health at Certificate of Death		eg No. 2007 0203
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Arafin Kromah		2. Date of Deal Month January 1	th 3 Time of Death
/ Linearda Exami		4a Facility Name (if not institution, give street and number)	4b. City, Town, o	January 1	4c County of Death
(Mercy Medical Center	Baltimore	Transported to Barrers	
Funeral Director		213-57-5158 1\overline{X}M 2\overline{F}	yrs. last birthday) 1 yrs. last birthday) 1 yrs. last birthday) 1 yrs. last birthday) 1 yrs. last birthday) Months Da	ys Hours Min.	th(MM/DD/YYYY) 9. Birthplace (State orunk Foreign Country) Liberia
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Location		10d Inside City Limits
land f show	5	MD Baltimore	Pikesville		1 Yes 2 X No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene wit: If item 27 is warked other than "natural", or items 23a or 28a-f show in other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 717 Milford Mill Road	10f. Zip Code	21208	Og. Citizen of What Country? unk-
death with or items 23	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?		lispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
fter dez I", or i		3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1 Yes 2 X N	o specify.	Specify: black
136 hin 72 hours after e than "natural", edical Examiner	ed by	15 Decedent's Education (Specify only highest grade complet	ted) 16a Decedent's Usual Occup during most of working life	ation (Give kind of work do each	16b. Kind of Business/Industry
036 thin 72 ne • than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA	Mover		Pro-Moving Co.
Baltimore, MD 21215-0036 germit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygene Important: If them 27 is warked other than 'injury or other traumatic event, the Medical injury or other tra	Be Cor	17. Father's Name (First, Middle, Last) Mohammed Koromah	unk	18.Mother's Name (First, Middle, N	Maiden Surname) unk
212 nould be d Menta s mark tic even		19a Informant's Name/Relationship (Type, Frint)	19b. Mailing Address (Stre	Leet and Number or Bural Route Num Road, Pikesvi	nber, City or Town State, Zip Code)
MD 2 and 2 shou lealth and N ten 27 is u		O.C.M.E.	20b. Place of Disposition (Name of c	reet bartimore,	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State	crematory or other place) King Memorial	2/3/07	Randallstown, MD
Baltimo permit. Pag Department Important: injury or of		4 Donation 5 KOther Specify in state 21 Signature of Runaral Services Licenses de, Direc	tor 23 Name and Addre	SEOFEACHTY BOARD 55 W	St Baltimore Street
Physician		23a. Parti. Enter the direase, complicitions that caused the	death. Do not enter the mode of dying		wabash Ave. Balto. MD 21215 est, shock, or heart Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Hanging			Between Onset and Death
		or condition resulting in death) Due to (or as a conseque	ence of):		
	iner	if any, leading to immediate cause. Enter Underlying Cause	ence of):		
ed ssit	Examiner	events resulting in death) Last Due to (or as a conseque	ence of):		
1760, ficate be executed g physician and sthe burial - transit	Medical	UNPENDED AMENDED			
760, ficate be g physical the burn	/Mec	IF FEMALE: 23c. If yes, outcome of the state		Cotonia assessassi	23d. Date of delivery
Box 687 e death certific the attending p	sician/	past 12 months? 4 Pregnant at time	2	Ectopic pregnancy	Month Day Year
ords, P.O. Box 687 w requires that the death certifi s been signed by the attending should be detached for use as it	Phys	Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause	given in Part I. 23e. Did to	bacco use contribute to the cause of death?
S, P.O.	d by			1 Yes	2 V No 3 Probably 4 Unknown
cords law requ has beer	Completed			24a. Was autop	
tal Rec cian: The l certificate l		25. Was case referred to medical	26 Pla	1 🗸 Yes	
Vital ysician: ihis certif	o Be	examiner?	2 ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 Other
Division of Vital Records, rate or Attending Physician: The law require rate of each from this certificate has been silled in by the funeral director, page 2 should be	on: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: Pay, Year)	FOUND:	yes 2 No 28d Describe I Subject han	now injury occurred ged self
ivision I or Attend after death Director:	Certification:	2 Accident Investigation Jan 11, 2007	1505 hrs 'Land' At home, farm, street, factory, office	building, etc. 28f Location (\$	Street and Number or Rural Route Number, City
Div spital o lours aft	Certi	4 Homicide determined (Specify) Jail/Pe	enal	or Town, S 300 E. Madiso	on St., Baltimore, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after dending Physician: The law requires that the death certificate be executed within 24 hours after dender. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	29a Certifier (Check only one) Certifying Physician: To the best of my known 2 Medical Examiner: On the basis of examina			
To To	Me	29b Signature and title of certifier	29c Licer	nse number	29d. Date signed (Month, Day, Year)
(5)		Jonna Leal		C.M.E.	January 12, 2007
9		 Name and address of person who completed caus of death Tasha Greenberg MD. Assistant Medical E 		, Baltimore, MD 21201	
Sí Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's S	Al Margalla D		
regis	للثالث	OHI CO COOL CONTRACTOR			

DHMH 17 Rev 1/2001 OCME 2006

			For State Ragistrar		State of	of Maryla	and / Dep <i>Ce</i>	artmen ertificat			nd M	ental Hy	giene Reg. No.	2007	02032
			1. Decedent's Name (First, M	iddle, Last)								2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medio Examir	cal	Alfred B. Ka 4a. Facility Name (If not instit		treet and nu	ımber)		4b. City,	Town, o	r Location of [Death	01	25	2007 County of Death	3:05 AM M
			4016 Kahlsto	n Road	đ			Ba	altir	nore			E	Baltimor	e
	Funeral		5. Social Security Number	6. Sex	M 2□F	7. Age (In y	rs. last birthday	/) If Under Months	1 Year Days		Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		212-30-2221 Usual Residence of Deceden			74	Yrs.					05/15/	1932	Mar	yland
	land ow		10a. State 10b. Con			10c.	City, Town or I	ocation							10d. fnside City Limits
	n the Marylan r 28e-f ehow	ō	MD Ba	ltimo	re	E	Baltimo	re							1 □ Yes 2√2 No
	h the	irec	10e. Street and Number					10f. Zip	Code				10g. Citiz	en of What Cou	intry?
1	th wit	aiD	4016 Kahlst	on Ro	ad			21	236				U.S	A.	
I	ae a a	ner	11. Marital Status	1	12. Was Dec Armed F	edent Ever in orces?	1 U.S. 13	. Was Dece	dent of H	lispanic Originan, Mexican, F	n? (Spe Puerto F	cify Yes or No Rican, etc.)	D- 1	4. Race - Ameri Black, White	
J. J.	S afte	by Funeral Director	1 Never Married 2		If Vac G	2 No		1 🗆 Yes		Specity:				Specify: Whi	
7 A	within 72 hours after death with the Maryland ane. then "natural", or iteme 23a or 28e-f ehow he Madical Examinar must be notified a	o pa		dent's Educ		Dates: Kor	1	edent's Usu	al Occur	ation				d of Business/Ir	
15.	in 72	Completed	(Specify only hi	ghest grade	completed)		(Giv		rk done	durina most o	f workir	ng .	TOD. KIN	d 01 Dusiness/11	idustry
12		E	Elementary/Secondary (0-1	2)	College ((1-4or 5+)	Mad	chinis	:+				Arm	co Stee	1 Co
		Bec	17. Father's Name (First, Mid	dle, Last)				J. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		18. Mother's	Name	(First, Middle			
	should by	P	Bernard Kah	1						Sue	T.	George			
ED	2 sho and fem		19a. Informant's Name/Relat	ionship (Typ	oe, Print)		19b. Mai	ling Address	(Street	and Number	or Rura	Route Numb	er, City or	Town, State, Zi	p Code)
	C = 14 F	5	Betty L. Kal	ıl (wi	.fe)	1006				n_Road				Tarylan	
1	ges 1 a trof Hear or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremat	ion 3 □Re	emoval from		o. Place of Disp cemetery, cr	ematory or o	me or other plac	ce)	U	ate	20c. Loc	ation - City or T	own, State
L FR	permit. Pages 1 Department of F Importent: if ite eny injury or ot once.	1 8	4 Donation 5 Othe				Parkwoo	d Cem	eter	y 01	/29,	/2007	_Ealt	imore,	Maryland
7 /	Departing on yield		21. Signature of Funeral Sen	/ICB License	98	/									Home, P.A.
1			23a. Part1. Enter the disease	e. or complic	cations that	caused the de								, Maryl	and 21087 Approximate
	Bis of the		shock, or heart faifure. Immediate Cause (Final	List only on	e cause on	each line	1	r 1		,				- 0	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		(or as a cons		truct	106	Li	MI	1 11	grag	4	
	Examiner				00010	(0) 43 4 00/13	soquerice or,								
		Jer	if any, leading to immediate cause. Enter Underlying) "	Due to	(or as a cons	sequence of):								
1,3	te be executed ysicien and he burial-transit	Examiner	that initiated events	, c.											
W	e exe		resulting in death) Last		Due to	(or as a cons	sequence of):								
9760	9 % 9	lical		d.											
BO Box 68	w requires that the death certifical been signed by the attending phishould be detached for use as the	by Physician/Med	IF FEMALE:	22	20 11 1100 01	standa of are	20000								
ď	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23	1 Live	itcome of pred birth 2 Fi nant at time o	etal death 3	□Ectopic p		,			23	3d. Date of deliv Month	rery Day Year
c	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkr		n dealin 5	□ Other (st	eciry)						
	that the	y Ph	Part II. Other significant con	ditions conf	tributing to d	teath but not i	resulting in the	underlying o	ause giv	en in Part I.		23e. Did 1	tobacco us	e contribute to	the cause of death?
2	aulres no sign									10	_	150	Yes 2□	No 3∏Pro	bably 4 Unknown
Ş	s bee	olete										24a. Was		24b. Were aut	opsy findings available
ă	The lav	Completed										auto perfo	psy ormed? 2 No	prior to co death? 1 \(\sum \subseteq \text{Yes}	ompletion of cause of
<u> </u>	nding Physician: "th. Ith. : After this certifica	BeC	25. Was case referred to me	dical						26. Place of	f Death	(Check only	-	1 163	2 10
>	nysici nis ce direc	TOB	examiner? 1 ☐ Yes 2 🔀 🎖 lo	He	ospital:	Inpatient 2	ER/Outpation	ent 3 DC	DA Oth	-		2		□Other (Speci	fy)
	ng Pt fter th		27. Manner of Death 1 Natural 5 ☐ Pe	ndina	28a. Date (Mor	of Injury oth, Day Year,	28b. Time	of 2	28c. Injur Wor	y at k?	2	8d. Describe	how injury	occurred	
	eath. or: A	catic	2 Accident inv	estigation uld not be				М		Yes 2 □No					
Division of Vital Becords	or Att	Certification:		termined	28e. Place build	e of Injury - A ling, etc. (Spe	t home, farm, s ecify)	treet, factor	y, office		2	8f. Location (City or To	Street and wn, State)	Number or Rur	al Route Number,
C	pital of urs all	Ce	00- 0-44-	A.I. Bh	la la a a 🔻 als										
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edicai	29a. Certifier 1. Cert (Check only 2 Medione)	ical Examin	ier: On the b	e best of my loasis of exame oner stated.	knowledge, dea lination and/or i	nvestigation	at the tir , in my o	ne, date and p pinion, death	occurre	nd due to the id at the time,	cause(s) a date and p	ind manner as solace, and due t	stated. to the cause(s)
	o the athin o the o the omple	Med	29b. Signature and title of ce	rtifier	A.	ta A		290	c. Licens	e number			29d. Date	signed (Month,	Day, Year)
	F S F ō) Jeffrer	ple	over	90 .		0	003	4650			1/2	5/17	
	117		30. Name d address of per	son who cor	mpleted cau	se of death (I	Item 23a) (Type		J				11	10/	
	1211		Jeffren Alan	lm	MD.		7.176	.,							
	Sta		31. Date filed Month, Day, Y		8	gegistrar's Sig	gnature	4							
	Regist	rar	JAN 2	! 6 200	n7 A	18 40	he 1	mark!							

DHMH 17 Rev 1/2001

ORIGINAL

07-00615 Sven O. Karell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certifi	cate of Death	and Me	ental Hygiene	20	07 0202
Physic Medical Exam	ian nine	1 Decadent's Name	ne (First, Midd					2. Date of D		3 Time of Death
ر سهور			if not institution	Sven 0. I	arell	4b. City, Tow	m os l onet -	January January	Day Year / 18, 2007	1800 hrs
		Shady Grov	∕e Hospital	·		Rockvill		n or Death	4c County of Montgome	
Funera Directo		5. Social Security 1 545-22-4 Usual Residence of	859	6. Sex 7. Ag	e (In yrs last b		Year If Un Days Hou	der 24Hrs. 8. Date of or Min. Marcl	Birth (MM/DD/YYYY)	· ·
w any		10a State	10b. County		10c. City, Tow	n or Location				1104
ne Maryland or 28a-f show fied at once,	Director	Maryland 10e. Street and Nur	Montg			Gaither			40. 00	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho	uneral Dir	214 Bri	stol D	owns Drive	Ever in U.S.		2087	1gin? (Specify Yes or I	10g. Citizen of What United S	States
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once.	by Fune	1 Never Marrie 3 X Widowed	4 Divo	rried Armed Forces? 1 X Yes 2 Irced If Yes, Give Year W	No.	If Yes, specify Cu	iban, Mexicai	n, Puerto Rican, etc.)	White, e	
2 hours "natu		15. Decedent's Ed Elementary/Seco	ucation (Spec	ify only highest grade com		Decedent's Usual Occuduring most of working	mation /Give	kind of work days	Specify: 16b. Kind of Busine	White ess/Industry
21215-0036 Mental Hygiene. market other than "natural", cevent, the Medical Examiner.	Completed	Lismonial y/occor		College (1-4 or 5 5+	+)	Librarian	ille. DO NO	use retired)	Educati	on
215- e filed tal Hyg ked off	Be Co	17. Father's Name (I						r's Name (First, Middle	Maiden Surname)	
21, nould b id Men is marl	To E	19a. Informant's Nar	ne/Relationshi	p (Type, Print)	19	b. Mailing Address (St	J	ohanna Ulr	ika Karlss	on
, MC and 2 st ealth an em 27 i		Leif K. I	Karell/	/Son	2.	14 Bristol D	owns D	rive, Gaith	ımber, City or Town, S Nersburg . M	tate, Zip Code) Jaryland 20877
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Med		1 X Burial 2	Cremation	3 Removal from Stat				Jan. 26,	20c. Location - City	or Town, State
altin mit P partme portan ury or		4 Donation 5 21. Signature of Fundamental Control of Fundamental Con	Other Spe	cify: censee	Tarki	ory or other place) awn Memoria Park	11	2007	Rockville	, Maryland
		Ny -	for		00198	Robert A.	Pumph	rey Funera	1 Home/Roc	ckville, Inc.
Physician /Medical				omplications that caused the each line.		ot enter the mode of dyir	ng, such as ca	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval
Examiner		Immediate Cause (Fi or condition resulting	nal disease in death)	Due to (or as a conseq	ma with Me	tastatic Disease				Between Onset and Death
\	ا <u>ة</u>	Sequentially list cond if any, leading to imm	litions,	b						
	Examiner	(Disease or injury that	ing Cause It initiated	Due to (or as a conseq.						
		events resulting in de	ath) Last	Due to (or as a consequent	uence of):					
760, cate be eve physician a he burial -	n/Medical	UNPENDED		AMENDED						
18760, rtificate be ing physic as the bur	Ž į	IF FEMALE: 3b. Was decedent pre	egnant in the	23c. If yes, outcome	of pregnancy				23d Date of deliver	ery
Box 687 The death certification is the attending properties as the for use as the form of	Physicial	past 12 months?	9 Unkno	4 Pregnant at tim	ne of death 5	Fetal death 3 Other (Specify)	Ectopic	pregnancy	Month	Day Year
ords, P.O. Box 68760, w requires that the death certificate be seen signed by the attending physicishould be detached for use as the buri				s contributing to death be	ut not resulting	in the underlying as				
ords, P.O. In requires that the as been signed by the should be detached.						arrane anderlying cause	given in Pan		bacco use contribute t	to the cause of death?
aw req	Completed							24a. Was a	an 24b. Were a	autopsy findings available
Vital Recor	5							autop: perfor 1 ✓ Yes 2	med? prior to death?	completion of cause of
Vital ysician his cert directo	en f	25. Was case referred examiner? 1 ✓ Yes 2	-	Hospital: 1 / Inpatient	2 5750		Other:	heck only one)	2 No 1 V	Yes 2 No
J of Jing Ph After t funeral	- 1-	7. Manner of Death	No	28a. Date of Injury		patient 3 DOA me of Injury 28c. Inju	Other a ury at Work?		Residence 6 Othe	er:
Division of Vital Records, tal or Attending Physician: The law requir as after death all Directors. After this certificate has been sited in by the funeral director, page 2 should be as a state of the funeral director, page 2 should be as a state of the funeral director, page 2 should be as a state of the funeral director, page 2 should be as a state of the funeral director, page 2 should be as a state of the funeral director, page 2 should be a state of the funeral director.		1 Natural 5 Accident	Pending Investiga	(Month, Day, Year)		1	Yes 2 N		ow injury occurred	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	311	Suicide 6 Homicide	Could no determin	t be 28e. Place of Injury ed (Specify)	- At home, farn	n, street, factory, office t	building, etc.	28f. Location (Stor Town, St.	treet and Number or R	ural Route Number, City
e Hosp 124 ho e Finne etely fi	- /	9a Certifier 1 Cer	tifying Physic	cian: To the best of my kn	owledge, death	Occurred at the time de	ate and alone			
To the II. within 24 To the F. complete	2	9b Signature and title) .	on the basis of examination and manner stated	ation and/or inve	estigation, in my opinion	n, death occur	red at the time, date a	(s) and manner as stated and place, and due to the state of the state	ted ne cause(s)
		organizative and title	of certifier	1/1/		29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
15-41	30). Name and address	of person who	comple, d c use of death	(Item 23a)	O.C.I	W. ∟ .		January 23, 200	7
	î.	Susan Hogan N	ID. Ass	istant Medical Exam	iner 111	Penn Street, Balt	imore, MD	21201	1900 - 1900 - 1900	
Stat Registra	e 31	Date filed (Month, D.		32. Registrar's S	gnature	Rock!				
HMH 17 Rev 1/2001		24/1	1 34 W	A STATE OF THE STA	OPIC	A Comment of the Comm				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1901 ottonsville saltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, October 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2□F Maryland 217-64-6473 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □Yes Ž No Director Baltimore Maryland Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be i Catonsville USA 1901 Fredeick Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Manager Painting traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Dean Richard Lally, Sr. Gay Blackwell ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra 1508 Ridge Road, Catonsville, Maryland 21228 Bryan R. Lally Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State = 5 N Burial 2 □ Cremation 3 □ Removal from State Department or Important: If any Injury or Crest Lawm Mem. Garden 1/24/2007 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Incensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Anonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vatural ause /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician a Physician/Medical attending p If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9∏Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Tyes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an rector, page 2 s autopsy performed Yes 2 No 1□ Yes director, 25. Was case refer ed to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 | Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

the Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral C

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 26

and address of person who completed cause of death (Item 23a) (Type, Print)

200

32 Registrar's Signature

and manner stated.

Itimore MD

29d. Date signed (Month, Day, Year)

29c. License number

D0050173

			1 - For Stata Registrar	State of	Marylar				ealth a Death		ental Hyg	jiene 2	007	02	035
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physici /Medic		Richard Melvin	Meist	er						January	00	2007	5:54	. A ^M
	Examin		4a. Facility Name (If not institution, giv	e street and num	ber)		4b. City	, Town, or	Location o	of Death		4c. Cou	inty of Death	1	
			Anne Arundel Med	ical Cen	ter			napo1				Ann	e Arun	del	
ı	Funeral		Social Security Number 6. S	Sex 7		. last birthday)	If Unde Months		If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day DEC • 24	Year)	9. Birth	place (State o	or Foreign
	Director		390-62-5323	2010 201	52	Yrs.					DEC. 24	, 195	4 Wis	consin	
	and and		Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. C	ity, Town or Lo	cation							10d. Inside C	ity Limits
	Aaryl • ho	ō	7 1 1 A	1.1	Α	12-									2X No
	28°-	Director	Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Co									of What Cou	intry?		
	death with the Maryland ms 23a or 28e-f ehow rmust be notified at												,		
	eath	Funerai	1833 Brett Court	12. Was Deced	tent Ever in L	J.S. 13.			spanic Orio	gin? (Spe	cify Yes or No-		A. Race - Amer	ican Indian.	
	iten d	ä	1 Never Married 2 Married	Armod For		1 1	If Yes, sp	ecify Cuba	n, Mexican	, Puerto I	Rican, etc.)	ı	Black, White	, etc.	
3	urs ar	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Da	107		1 🗌 Yes	2⊠ No	Specify:			Spe	ecify: Whi	.te	
D-0-0	be filed within 72 hours after death with the Marylan Hygiene. d other than "netural; or items 23s or 28s-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's E	ducation		16a. Dece							f Business/Ir		
7	hin 7	pie	(Specify onfy highest grant Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	use retired	turing most)	t ot workii	ng				
V	d wit	DO.	12			System	ms Si	pecia	list			Comm	unicat	ions	
and	of Hy	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden Sun	пате)		
<u>a</u>	Aenta Aenta rked rice	10	James Howard Mei	ster					Jacq	ueli	ne Mary	Blah	nik		
a S	2 should be filed within n and Mental Hygiene. Fis marked other then "reumatic event, the Mecons.		19a. Informant's Name/Relationship (Туре, Print)		19b. Mailir	ng Addres	s (Street a	ind Numbe	er or Rura	i Route Numbe	r, City or To	wn, State, Zi	p Code)	
Σ	and 2 alth 127 i		Jacqueline Meist	er (Moth	er)	4188	Bay S	Shore	Dr.,	Stu	rgeon B	ay, W	I 5423	5	
ore	of He of Her		20a. Method of Disposition	3D	20b.	Place of Dispo cemetery, cres	sition (Na	ame of other place	e)	D	ate	20c. Location	on - City or T	own, State	
Ĕ	Page nent int: If		1 ☐ Burial 2 【ACremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Special		late	tropol:			į.	1/2	5/07	Alexa	ndria,	VA	
Saitimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic ev 900.0.		21. Signature of Juneral Service Lies	nSpee _		22	2. Name a	nd Addres	s of Facility	y					
ם	89 E 2 8		* cunick	Minu	u	1	uehns 414 l	s Fun Michi	eral gan S	Home	Sturgeo	n Bay	, WI 5	4235	
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the dea				_					Approximat Interval Bet	.e ween
Ja.	Physician		Immediate Cause (Final disease or condition	N- 4	(1 50	in f		han					Onset and	
	/Medical		resulting in death)	aDue to (b	r as a consec	quence of):	174	arc	(IOT)					Noor	3
	Examiner			h	ment	inide	nía							VOAR	. 9
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (r as a consec		21100							1000	
1	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c											
o o	en ar	EX	resulting in death) Last	Due to (o	ras a consec	quence of):									
000	certificate be executed iding physicien and use as the burial-transit	dicai		d											
0	ng ph as tl	Jed	IF FEMALE:												
5	th ce tendii r use	hysician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live bir	ome of pregn th 2 Peta		Ectopic i	pregnancy				1	Date of deliv	,	
	death	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of		Other (s						Month	Day '	Year
	et the	چ	9 🗆 Unknown								-				
'n	The law requires that the death certific are hes been signed by the attending p page 2 should be detached for use as I	by P	Part II. Other significant conditions	contributing to dea	th but not res	sufting in the u	nderlying	cause give	en in Part I.		23a. Did to	bacco use c	ontribute to	the cause of c	leath?
cords,	en si bu(d	ed	hypertensic	N							10509	es 2□No	o 3∏Pro	bably 4 □l	Unknown
ร	aw re	Completed	- smoking								24a. Was a		b. Were aut	opsy findings	available
Ĕ	The The sage	E	0				-				autops perfor		death?	ompletion of c 2□ No	ause o
V 11.02	an:	0	25. Was case referred to medical						26. Place	of Death	Check only or	1	1 2 103	20110	
>	ysici is ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ In	patient 2] ER/Outpatier	1 3 2 10	OA Othe	NP		ne 5 🗆 Resid		Other (Speci	fy)	
0	og Ph ter th seral		27. Manner of Death	28a. Date of (Month	Injury Day Year	28b. Time of		28c. Injury Work			28d. Describe h			<i>"</i>	
2	ath. r: Aff	ertification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		, bay rour,	Підоту	М		res 2□h	No					
	Atte	illic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o	of Injury - At h	nome, farm, str	eet, facto	ry, office		2	28f. Location (S City or Tow	treet and Nu	ımber or Rur	al Route Num	iber,
5	s effe	Cer	- Commondo	Danding	g, etc. (<i>opeci</i>	'97					Only or row.	i, Siale)			
	To the Hospital or Attending Physician: The law within 24 burus elter death. To the Funerel Director: After this certificate hes i completely filled in by the funeral director, page 2 s		29a. Certifier 1 Certifying Pl	nysician: To the t	est of my kn	owledge, death	occurre	d at the tim	e, date and	d place, a	and due to the c	ause(s) and	manner as	stated.	
	he H in 24 he Fi pleter	edicai	(Check only 2 Medical Examone)	and manne	or stated.	ation and/or in	vestigatio	n, in my op	onion, deat	ın occurre	su at the time, o	ate and plac	ce, and due t	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	0	0 -		29	c. License	number		2	9d. Date sig	ned (Month,	Day, Year)	
•			Janice Ki	HRAIS.	the.)	NO		021	7513			1/24	1/07		
	10		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print)					141	/		
	W		Janice RUTKOU	USKI, MO		215 A	nnaj	olis	Rd	0	denton,	MO	2111	3	
	Sta		31. Date filed (Month, Day, Year)	32.40	gistrar's Sign	ature	make.	2							
	Reaistr	ar	141175	1111/ 1 2	136 - 0	14 1	CSP BREEK								

			For State Registrar	State of Maryla		tificate of			Reg. No	07	02036	
y .	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Raymond J	MAZZA	FERRE	os s		2. Date of De. Month	2 ^{Day}	O7	3. Time of Death	
	Examin	er	4a. Facility Name (If not institution, give s Baltimorele habilit	treer and number)	ded Care	4b. City, Town, o	Raltim	ra MI	4c. Coun	ty of Death		
	Funeral	240	5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da		9. Birthp	lace (State or Foreign	
2	Director	-	170-32-5954 Usual Residence of Decedent	65	Yrs.			Feb. 8		Penn	sylvania	
	ryland		10a. State 10b. County	10c.	City, Town or Loc	ation				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	death with the Maryland ms 23a or 28a-f show	Directo	Maryland Carroll 10e. Street and Number	Sy	kesvill	e 10f. Zip Code			10g, Citizen o	f What Cour		
	3a or		6511 Carroll Highl	ands Road		21784			U.S.A.		,	
36	n 72 hours after death w "nature!", or Items 23a adical Examinal must.	by Funeral		2. Was Decedent Ever in Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	If	as Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ace - Americ ack, White, ify: Whi	etc.	
5-0036	72 hou naturs dical E		15, Decedent's Educ (Specify only highest grade	ation	16a. Deced	ent's Usual Occup	ation during most of worki	in <i>a</i>	16b. Kind of			
2	within one one than "I	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	orer	d)	Ĵ	Tech-	School	1	
Maryland 21	Hygi Hygi other	Be Co	17. Father's Name (First, Middle, Last)		Пар	orer	18. Mother's Name	e (First, Middle,		-		
<u>ya</u>		To	James Mazzaferro		10h Mailia	- Address (Cassa	Pauline and Number or Rura			- State 7in	Codol	
-	d 2 s th ar 7 ls trau		19a. Inlormant's Name/Relationship (Typ. Lynn Mazzaferro/Wi				Highlands					
more,	00		20a. Method of Disposition 1 □ Burial 2 【Cremation 3 □ Re	20b emoval from State	p. Place of Dispos cemetery, crem	sition (Name of natory or other place	ce)	Date	20c. Location	n - City or To	own, State	
Baltin	permit. Page Department (Important: If sny injury or once.		4 □ Denation 5 □ Other (Specify) 21. Signature of Funeral Service License		22.	Name and Addre		mes F.	Fergus	on Fu	neral Home	
	40 E # 0	, j	23a. Part1. Enter the disease, or compli	cations that caused the de			rket, Bla			1571	Approximate Interval Between	
1	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) I Sehemic Carcliomy apathy Due to (or as a consequence of): Extensive Atheroselerotic Coromany Artery Deasel									
			Sequentially list conditions.	Extensive	sequence of): 2 A the r	oselero	tiecora	nary A	Inter of	Sas	e	
/	s insit	miner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
/ 20	ficate be executed physicien and s the burial-transit	al Examin								No. of the latest states and the latest stat	-	
68760,		edical	d									
P.O. Box	The law requires that the death certif ste has been signed by the attending bege 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	у			23d. Date of delivery Month Day Year					
	w requires that the de been signed by the a should be detached	þ	O . c. Lealer MAOLITHUS							23e. Did tobacco use contribute to the cause of de		
eco	lawren as bee	Completed	thy	pertensia	i			24a. Was		prior to co	psy lindings available mpletion of cause of	
a R	r: The icate h		4	Dyslipio	loma			1 Tes	2 No	death?	2 No	
Ž	ysiciar s certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	! ☐ ER/Outpatien	t 3 DOA Ott	26. Place of Death ner: 4 \(\sum \) Nursing Ho			ther (Specif	WHO Save O	
Division of Vital Records,	Attending Physician: r death. ector: After this certifice by the funeral director. E	tion: T	27. Manner of reath 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Inju	ry at	28d. Describe			Hot se	
Divis	after des Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street, City or Town, Street, Lactory)							mber or Rura	al Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my ter: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the treestigation, in my c	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as s e, and due to	tated. o the cause(s)	
	To the To the To the Complet	Me	29b. Signature and little of certifier	2		29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)	
	/		SCH/cl	\sim \sim \sim \sim		04	1218		01/	77/	07	
	15	1	30. Name and address of person who co	mpleted cause of death (item 23a) (Type, 3900 L<i>0</i>	ch Rav	en Blud.	Bolt	imore	MD	21218	
1	Sta Registi			32. Registrar's Si	gnature	1 10			/			

DHMH 17 Rev 1/2001

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			For Amend Items 7 1 - Stata Registrar	7,583126 3121712171	Ce	acted of rtificate of	26/074116 Death	Mental Hyg	ienę _{eg. No.}	07	02037
	Dhusiai		1. Decedent's Name (First, Middle, Last,					Date of Deat Month		Year	3. Time of Death
	Physici /Medic		Glen Edward Ma			· · · · · · · · · · · · · · · · · · ·		Jan.	03 ^{ay} 20	᠐᠐ᢆ	1045р м
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea	th	4c. County	of Death	
			2311 E. Presto 5. Social Security Number 6. Securi		to a finish at a second	Baltimo		O Date of Bigs	1060	0.0014	
	Funeral Director				n yrs. last birthday) 2 38 Yrs.	Months Days	Hours Min	. (Month, Day,	Year)	Cou	place (State or Foreign ntry)
			Usual Residence of Decedent	1	<u> </u>			10-27	- 50	MD	
	yland		10a. State 10b. County	10	c. City, Town or L	ocation					10d. Inside City Limits
	Mar a-f	ţ	MD		Baltim	ore					1 □XYes 2 □ No
	or 28	Oire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Cou	ntry?
	23a	la	2309 E. Lafaye			2121	3		USA		
	tems and	Funeral Director		12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - Ameri ck, White,	can Indian, etc.
36	s afte	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify		
Ş	72 hours after death with the Maryland naturel', or items 23s or 28s-f ehow deat Examinar nast be notified at	ed	15. Decedent's Edu		16a Dece	edent's Usuaf Occup	ation		16b. Kind of Bi	Blac	
21215-0036	n n	Completed	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retired	during most of wo	orking	Tob. Tana of Di	33.1103.311	idustry
212	od within giene. er then "	E	11th	College (1-4or 5+)	Di	sabled			Lifet	ime	
9	be filed ital Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, I	Maiden Suman	ne)	
<u>la</u>	should be nd Menta marked	2	Melvin Botts				Susie	Mayden			
Maryland	2 shoul and Mi ie mari		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ing Address (Street	and Number or R	ural Route Number	. City or Town,	State, Zip	o Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hygiene if Heelth and Mental Hygiene it them 27 is marked other then "naturel", or items 23s or 28s-f show other treumatic event, the Medical Exemplant most be notified at		Susie Botts Mo			E. Pres	ston St				
or B	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	1	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location -	City or To	own, State
Ē	tant:		4 Donation 5 Other (Specify)		Mt Carm				Baltim		MD
Baltimore,	permit. Pages 1 Department of H important: If ite any injury or ot once.		21. Signature of Funeral Service Licens	99	W	2. Name and Addre	ss of Facility 1avis J	r Funera	al Hom	ne	
_	40240		23a. Part1. Enter the disease, or compl		2	007 East	ern Av	e Balti	more M		1231 Approximate
}	Physician		shock, or heart failure. List only or fmmediate Cause (Final disease or condition	ne cause on each line.		uceph	,		9 51,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	5 1		ha			, P
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	57 % G	to 10t	NAL	10250	ase	C	MONDWY
	nsit	ir	cause. Enter Underlying Cause (Disease or injury	Cald	1 100 6 5 1	nashia				- 1	12/
	execu n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	711/27					
8760,	cate be executed physicien and the burial-transit	dicai		AII	25					L	IN END WX
9	tificat ig ph) as th	•									
Вох	death certific e attending p id for use as	J.	230. Was decedent pregnant	3c. If yes, outcome of p		□Ectopic pregnancy			23d. Da	te of defiv	ery
	o dea	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim 9☐ Unknown		Other (specify)			Mo	onth	Day Year
<u>о</u> .	et the de d by the a etached	by Physician/M	9 Unknown					1			
Ś	res the igned be be det		Part fl. Other significant conditions con	ninbuting to death but n	ot resulting in the u	underlying cause giv	en in Part I.				he cause of death?
5	law requires thet es been signed b 2 should be deta	Completed						1 L Ye	es 2□No	3 Prot	bably 4 Dienknown
Record	e law hes b	npie						24a. Was a autops	n 24b.	Were auto	opsy findings available ompfetion of cause of
_	Page T	ខ						perform 1 ☐ Yes		death? 1 🗌 Yes	2 □ No
Vital	Physician: This certifice al director, p	Be	25. Was case referred to medical examiner?	losnital:		Oth		ath Check only on			Mothers
ō	Phys r this ral dii	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	lospital: Hinpatient 28a. Date of Injury	2 ER/Outpatie		4 Nursing i	Home 5 Recide	once 6 □Oth	er (Specil	Residence
Division	ding Ph. h. After thi funeral	ţi	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	Wor	k? Yes 2 □ No	200. Describe in	ow injury occuri	180	
isi	I or Attending after deeth. Director: Afte I in by the fune	fica	3 Suicide 6 Could not be	28e. Pface of Injury	- At home, farm, st			28f. Location (St	reet and Numb	er or Run	al Route Number.
á	after i Dire	Certification:	4 Homicide determined	building, etc. (3	Specify)	, ,		City or Town			
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical C	29a. Certifier Cartifying Phy (Check only one)	sician: To the best of m	amination and/or in	th occurred at the tir	me, date and plac pinion, death occ	e, and due to the coursed at the time, d	ause(s) and ma ate and place,	anner as s	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated		29c. Licens					
	E NE S		0.77/2	<u> </u>	- m	0-	. 7 3 3			(Man),	7 - 1
7	(i)		30. Name and address of person who co	ompleted cause of death	h (Item 23a) /Tur-	Print)	0120	5	an	/	1007
	_	(TIME A TIBONA	ec um	M 3	O 57	PAU	1-PL	B.	14	Day, Year) 2007 2007 214
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature				KI 6	LIX	200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 22, 200^{Yea} Thomas Joseph McDermott 8:25 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Rosedale Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, **Funeral** Months Days Hours **1** 2 □ F Min. 11/22/1946 214-50-2745 Director 60 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical <u>Examiner must be notified at</u> Director 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Mango Trail 21220 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 💥 No Specify: à Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Operator Glass Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Joseph McDermott Minnie Mae Webb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McDermott (Wife) 3 Mango Trail, Baltimore, Maryland 21220 Department of Heall Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 【※Cremation 3 ☐ Removal from State Bayview Crematory 1/24/2007 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Fundal Server Users 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Fastern Avenue, Essex, Maryalnd 21221 23a. Part - Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Thrombotic Thrombocytopenic Purpura /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transi $l_{\mathbb{A}}$ Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day 5 ☐ Other (specify) signed by the a d be detached f P.0. ☐ Yes 2☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy certificate 1□ Yes 2 **X** No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) r this c 1 ☐ Yes 2 XNo 1 🔀 Inpatient P 2 ER/Outpatient 3 DOA uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending Natural Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the Funeral Director: npletely filled in by the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 1/2001

after hours

within 24

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determined

who completed

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f certif

JAN 2 6 2007

and manner stated.

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4 ☐ Homicide

(Check only one)

30. Name and address of

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature

Medical

State

Thomas

Moderatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RES000

29c. License number

9000 Franklin Square Dr., Balto., Md. 21237

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) January 23, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ELLIOTT A. NELSON , SR. 2007 TATUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE N/A Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**∑** M 2□ F 79 Director 212-22-3429 09/11/1927 MARYLAND Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at XXes 2 No N/A MD Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4304 KATHLAND AVENUE or iteme 23a 21207 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 192]Yes 2 □ No US IfYes, Give Year or Dates: ARM 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: BLACK Specify. ARMY 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) could be filed within 72 I Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR RETAIL SALES 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHRISTOPHER NELSON is marked c Pages 1 and 2 should be iment of Health and Menta tant: If Item 27 is marked MARIA NELSON ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLIOTT A. NELSON, JR/SON 4304 KATHLAND AVE., BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date N☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò permit. Page Department of Important: If any injury or ance. MD VETERANS CEM. 02/01/07 OWINGS MILLS, MD CARRISON FOREST 22. Name and Address of Facility neral Service Licenses 21. Signature of F HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD the the deease, or complications that caused the deck, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SMALL CELL CARGNEMA of THE LUNG Non /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No CORONARY ARTERY DISEASE PROGTATE CANCER 1 ☐ Yes 21/2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 KEP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 XNatural 2 ☐ Accident 5 Pending nours after death.

nerel Director: After filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the hospital c within 24 hours at To the Funerel D completely filled in 29a. Certifier Kertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title di-certifier

State Registrar

JAN 2 6 2007 DHMH 17 Rev 1/2001

KAYNOLD

31. Date filed (Month, Day, Year)

Lose 1

D27157

310-1-10 BATIMONE DR. BOLTIMORE, MD 21246

JANUARY 26, 2007

MD

32. Registrar's Signature

30. Name and address of person who completed use of death (Item 23a) (Type, Print)

DEPESTAE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ng. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 2007 07:45P M Henry Albert Nearhood /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F Months Yrs Director 204-28-1200 7/9/1935 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2万 No notified Director 28a-f Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: for Items 23a or Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be read in the Medical Examiner must be read to the medical Examiner must be read to the medical Examiner must be read to the medical 2301 Pentland Drive Funeral Apt 310 21234 S. A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: (1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: White Specify à 3X Widowed 4 □ Divorced (Unknown) Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Driver Tool Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I nt: If item 27 is marked o ဥ Albert Nearhood Marv Elizabeth Seiber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert Joseph Nearhood (Son) 19 Scarborough Fare Stewartstown, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1/25 1 ☐ Burial 2 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 2007 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PERFORATED BOWEL /Medical Due to (or as a consequence of) Examiner GRAM POSITIVE BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). physician and states the burial-transit certificate be executed CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of). Box 68760. Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a, Was an has page 2 autops certificate 2 No 1□ Yes 2 **X**No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one) Be Hospital: 1 Yes 2 No 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this r 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 🗆 No To the Hospital or Attend within 24 hours after death To the Funeral Director: the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

JAN 2 6 2007

M. D.

TIMOTHY LOW.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

7601 OSLER DRIVE

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 1027 a N 232007 /Medical M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vorthe RANDALLSTOWN BALTIMORE 8. Date of Birth 01/01/1938 5. Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□M 2□ Months Days Hours Min. D.C. 69 215-36-3554 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director REISTERSTOWN 1 ☐ Yes 2 X No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21136 USA 24 FALLS CHAPEL WAY Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No ģ Specify. Specify 3 ☐ Widowed 4 🎝 Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WATS VERNSTEIN ALTCF JOHN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE WALKER / DAUGHTER 24 FALLS CHAPEL WAY - REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State FT. LINCOLN CEMETERY | 01/25/2007 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matrice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NOSED /Medical to (or as a con a quence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical The law requires that the death certificate the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2X No certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 1 npatient P 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 ☐ Pending investigation within 24 hours after deau. To the Funeral Director: Af 2 Accident 1 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Benjamm MEREL

State Registrar 30. Name and address of pers

4000 31. Date filed (Month, Day,

06

DHMH 17 Rev 1/2001

on who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of	Marylan		artmen rtificat			and M	•	giene Reg. No.	007	020	42
ř	Physic		1. Decedent's Name (First, Middle, La: William Donald		erson						2. Date of De Month Janua	Day	, 2007	3. Time of	Death 15 ½
220	/Medi Examir		4a. Facility Name (If not institution, give Potomac Valley					Town, or	Location o	of Death		4c. C	ounty of Dea	th	
	Funeral Director		5. Social Security Number 6. S 577-48-7393 1	ex 7. XΩM 2□F	Age (In yrs. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 2	th av. Year) I, 19	9. Bir 23 Bar	thplace (State or ountry) nard, Ki	Foreign S
	a-f ehow	ctor	Usual Residence of Decedent	omery		y, Town or Lo								10d. Inside Cit	•
	3a or 28	i Dire	10e. Street and Number 1235 Potomac Val:	ley Road			10f. Zip	Code 850					on of What Co		
036	in 72 hours after deeth with the Maryland "natural", or items 23a or 28a-f show redical Expense must be recitified at	by Funeral Director	11. Marital Status ↑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Forc 1 Types 2 If Yes, Give Year or Date	es? □No 1Ω/		Was Deced If Yes, spec	_	spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Black, Whi	erican Indian, te, etc. hite	
21215-0036	d within 72 plene. r then "nai	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		or 5+)		dent's Usua kind of wo DO NOT us npute	rk done d se retired	luring most)		ng	Wo	of Business oodie' atalog	Reta	
Maryland	d 2 should be filed th and Mental Hygi ?? Is marked other traumatic event.	To Be C	17. Father's Name (First, Middle, Last) Edward Cheste 19a. Informant's Name/Relationship (Petters	son	10h Maili	a Addrasa	(Street a	Mar	y Fr	ances S	Smith		Zin Codol	
	1 an Heal		Stacey Johnson, 1				51 S.	Dah:	lia C	t. C	entenni Date	ial, (CO 801		
Baltimore,	permit. Pages Department of I Important: If its eny injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer	1)	216	nesapea	ake C	rema	tory s of Facilit	y Ra	2/07 pp Fonc ilver S	Bel ral a	tsvil		Svs.
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	ised the death	/	er the mod	e of dying	such as	cardiac c	or respiratory a	rrest,	, FID	Approximate Interval Betw Onset and D	veen
8760, %	death certificate be executed as a strength of the certificate be extending physicien and an indicate as the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. A Due to (or c.	as a consequence of the conseque	v (EC) uence of): A Y	Av	ene tev	nti	a Dis	Ser S.	c l			
P.O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Fetal ntattime of de	Ideath 3□	Ectopic pr					23	d. Date of de Month	- /	'ear
	se ngi	Ď	Part II. Other significant conditions c	ontributing to dea	th but not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did t			the cause of de	
Division of Vital Records,	The ate h page	Completed									24a. Was autor perfo		24b. Were a prior to death? 1 ☐ Yes	utopsy findings a completion of ca	available ause of
Z X	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	atient 2 🗆	ER/Outpatier	it 3 DC	Othe			n <i>(Check only o</i> me 5 ☐ Resi		Other (Spe	cifv)	
ion of	ding Ph h. After th funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,	Injury Day Year)	28b. Time or Injury		8c. Injury Work		2	28d. Describe				
Divis	o et in	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	280. Place 0	Injury - At ho , etc. <i>(Specif</i> y	ome, farm, str	eet, factory	r, office		1	28f. Location (. City or To	Street and i wn, State)	Number or R	ural Route Numb	ber,
	Hospital 24 hours a Funeral I letely filled	edicai	29a. Certifier 1 Certifying Ph	ysician: To the b niner: On the bas and manne	is of examinat	wledge, death tion and/or in	n occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	s stated. to the cause(s)	
)	To th within To th comp	Me	29b. Signature and title of contifier 25 E SON	1001	v /	NO	290	License	number 562	43	5	29d. Date	signed (Mont	n, Day, Year) ZOO MD ZO	7
100	154,		30. Name and address of person who SATED ECS 31. Date filed (Month, Day, Year)	AYYAL	of death (Item 291) jstrar's Signa	23a) (Type,	Print)	20	ente	+ I	Jr. Re	beku	itle,	MO 20	850
	Sta Registi	4	IAN 2 6	1 1	7	H	land.	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 2 1 Decedent's Name (First, Middle, Last) Month Year **Physician** POLLOCK 23 January 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner BURNIE ANNE ARUNDEZ BALTIMORE WASHINGTUN MEDICAN GLEN ENTER 8. Date of Birth (Month, Day, Year) 2/6/1944 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months 1 XM 2 ☐ F Yrs 62 Director 217-40-1553 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10h County 28a-f show 1 ☐ Yes 2 No Director Maryland | Anne Arundel Glen Burnie 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ò than "natural", or items 23a 21060 S. A. 1008 Upton Road Injury or other traumatic event, the Medical Examiner must Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces: 1 XYes 2 No If Yes, Give 1964 Year or Dates: 1967 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Grinder Electrical permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important; If item 27 is marked other any Injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pollock ဥ Cloud Eleanor Carey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21060 Dolores Pollock (Wife) 1008 Upton Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1/26 2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oxford Cemetery Oxford, Pennsylvania 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Ecchael 50. afferen Approximate Interval Between Onset and Death er 4 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. 23a. Part1. Enter the disease, or per plicate shock, or heart failure. List only of the Immediate Cause (Final weat peritoni **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner year s Irr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) ed by the a detached f ☐ Yes 2☐ No 9□Unknown 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★No 24a. Was an autopsy performed? 1□ Yes 2☑ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☑ Inpatient 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Matural M 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Machinian Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 74987 200 m() harles & Wiles mis 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive Glen Burnie MD Washing Medicul Balti ware Center 301 tou 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		For Amend Ito	State pe Marylan	d / 6863 Cer	tifica	26/0/dflb an te of Death	d Mental	Hygie Reg.		02044
		1. Decedent's Name (First, Middle, Las	t)				2. Date	of Death	Day Year	3. Time of Death
Physici /Medic		BELWICE G	UEEN					WARY	17 200	
Examin		4a. Facility Name (If not institution, give	street and number)		_ `	, Town, or Location of D	eath		4c. County of Dea	ith
		HARBOR ITUSPITI 5. Social Security Number 6. S	T. Age (In yrs.	last hirthday)	-	TIMOLE, or 1 Year If Under 24	Hrs. 8. Date	of Birth	9. Bir	rthplace (State or Foreign
uneral irector			OM 200F 77	7 Yrs.	Months		Vin. (Mor	of Birth oth, Day, Ye	1929 N	1 ARYLAND
M II		10a. State 10b. County	10c. Cit	y, Town or Lo	cation	0		d		10d. Inside City Limits
or other traumatic event, the Madigal Examinar must be notified at	ctor	MARYLAND M)/A				HORE		77/	1 ⊠Yes 2 □ No
2	Dire	10e. Street and Number		_	10f. Z	ip Code	235	10g.	Citizen of What C	ountry?
1	erai	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Was Dec	edent of Hispanic Origin	? (Specify Yes	or No-	14. Race - Am	erican Indian,
STATE STATE OF	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1		edent of Hispanic Origin ecify Cuban, Mexican, P 2 No Specify:	uerto Rican, e	tc.)	Black, Wh	ite, etc.
	ed b	15. Decedent's Ed	lucation	16a. Deced	dent's Us	ual Occupation		168	b. Kind of Business	s/Industry
	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of w DO NOT	ork done during most of use retired)	f working		- 1	,
	DO.	UNKNOWN		Ho	ME	MAKER				TOME
	Be	17. Father's Name (First, Middle, Last)	\wedge		1	18. Mother's	Name (First,	Middle, Mai	iden Sumame)	4 0
	မ	L0015	φ	UEE	N	MA	RY	No-to-	PAZ	MER
		19a. Informant's Name/Relationship (1 (SON)	190. Mailir	ng Addre	ss (Street and Number o	or Hujai Houte	Number, C	RAJ ==	Zip Code)
the.	18	20a. Method of Disposition	20b. P	lace of Dispo	sition (N	ame of	Date	200	c. Location - City o	r Town, State
0 0	- 4	12 Burial 2 ☐ Cremation 3 ☐	Hemoval from State	emetery, crer T, ZI 0	- 1' -	other place) EMETERI ()	1 2/1-	17/	4N500W.	IE MA
eny injury pnce.		4 ☐ Donation 5 ☐ Other (Specification of Fundamental Service Lice)				and Address of Facility	- 97 C	1 70	FILME.	RAL HOME
eny injury or other tr once.) (a) om		199	F8 11. 15/2	TON	WE	BALTO. A	10.2/2/7
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not ent	er the m	ode of dying, such as ca	rdiac or respira	atory arrest		Approximate Interval Between
all	. 0	Immediate Cause (Final	SEPS	15						Onset and Death
al		disease or condition resulting in death)	aDue_to (pr as a conseq		-					2 20073
er		Sequentially list conditions,	1 Meum	onia						23 Days
	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence ol):						
the burlat-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						
2	icai E		D00 10 101 00 00 001000	301100 0.7.						
		•	d							
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of de	elivery
20 000 101 000 000	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d		Ectopic Other (pregnancy specify)			Month	Day Year
	hysi	9 Unknown	9□ Unknown							
	by P	Part II. Other significant conditions of		,	1		230	e. Did tobac	cco use contribute	to the cause of death?
a D	ed	Dissemina	ted Intravas	sculu	- (agulo, sutt	7	1 🗌 Yes	2 □ No 3 □ F	Probably 4 Dunknown
2 should	Completed						24	a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
	ĕ						1	performe Yes 2	d? death?	s 2□No
director, page z	Be	25. Was case referred to medical examiner?				26. Place of	f Death (Checi	k only one)		
9	2	1 ☐ Yes 2 X No		ER/Outpatier					e 6 □Other (Sp	ecify)
unera		27. Manner	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?		scribe how	injury occurred	
the	Certification:	2 Accident investigation 3 Suicide 6 Could not be			M	1 ☐ Yes 2 ☐ No		ation /Stron	at and Number or I	Rural Route Number.
in by	it	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia		reet, ract	огу, опісе	City	or Town, S	State)	HUIAI HUIJE NUITBEI,
completely filled in by the funeral di	edical Ce	(Check only 2 Medical Exa	nysician: To the best of my kno niner: On the basis of examina							
pied	Med	one)	and manner stated.			9c. License number		29d	. Date signed (Moi	oth Day Yearl
3	-	29b. Signature and title of certifier	11/1/-					250	11/17/	, ,
	1	/ fund	may up	- 22c) (T		RESOUC)		1111	0 /
		30. Name and address of person who				ANCUER ST	2017	MADRE	140 01	225
		31. Date liled (Month, Day, Year)	AFAEL 300		7 14	TIUCUEIL SI	DITLI	MUICE	, MU AL	VV-7
St Regist	ate	IAN 2 6 2007	March Ho	Boards	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Year Month James Henry Rushford 7, 10:00 PM January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Montgomery Hospice Casey House Rockville Montgomery rth ay, Year) 19, 1942 West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1⊠M 2□F Months Sept. 302-36-0025 64 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 11510 Highland Farm Road United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates: 1960-63 1 X Never Married 2 ☐ Married 1 ☐ Yes 2**忆** No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Consultant Wholesale Imports 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Alexander Rushford Ethel Bragg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12124 Orchard View Rd., Gaithersburg, MD 20878 John R. Copenhaver / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Livensee Robert A. Pumphrey Funeral Home/Rockville, M00896 300 W. Montgomery Ave., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Just only one cause on each line. Non Hodgkins Lymphoma Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

January 8, 2007

Physician /Medical **Examiner**

> and burial-trar

the

Physician

/Medical

Examiner

Funeral Director

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event."

cate has been signed by page 2 should be detact

or Attending Physician; The law requires that the death certificate be executed

certificate }

After this

within 24 hours after death

To the Funeral Director;
completely filled in by the

Hospital

funeral director,

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1∐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🖾 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c, License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year)

341

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 2

6

nthia m Hilliams DO

Cynthia M. Williams, D.O., 6001 Muncaster Mill Rd., Rockville, Maryland 20855 31. Date filed (Month, Day, Year)

H005803Z

State Registrar

32 Registrar's Signature

			1 - For Amend #2&29d Registrar	State of Marylar per Phy G863 1	726/07	artment o	of Health of Death	and M	ental Hy	giene (Reg. No.	007	02046
			1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	2007	3. Time of Death
	Physici /Medio		STEP	MEN		兴 2	1TKA	9 .	JANUA		2006	7:40AM
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4			Bon Secour Hospi	ital		Balt	imore					
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 You Months Da	ear If Under	24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birthp	lace (State or Foreign
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	pur .		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation					1	0d. Inside City Limits
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	188-1	Director	Maryland		Baltimo					10 07	7.110	
	with t	ä	10e. Street and Number	Falls Parkway A	ht D	10f. Zip Coo				USA	of What Cour	itry ?
	within 72 hours after death with the Maryland ane. than "naturel", or Iteme 23e or 28e-f ehow he Wajisal Examiner must be notified at	Funeral		12. Was Decedent Ever in U				-i=i=2 /S===	offic Vac or No		Race - Americ	eno lodino
	ltem Der de	Š	11. Marital Status 1 → Never Married 2 → Married	Armed Forces?	.5.	Was Decedent If Yes, specify (Cuban, Mexica	n, Puerto F	Rican, etc.)	14.	Black, White,	
36	rs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🔀	No Specify	:		Spe	ecity: Whi	te
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	Hygie other	0	17. Father's Name (First, Middle, Last,)	•		18. Moth	er's Name	(First, Middle,			.0
<u>a</u>	Mental Mental arked o	ToB	Stephen Rutk	ta				Maril	Lyn Owe	n		
Maryland	S D E E	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Str	reet and Numb	er or Rural	Route Numbe	er, City or To	wn, State, Zip	Code)
	and 2 ealth a n 27 ie		Marilyn Rutka -	Mother	2608	Einwood	d Drive	: Kis	ssimmee	. FL 3	34758	
Baltimore,	S 1 a		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name o	t		ate		on - City or To	wn, State
Ë	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State		Cremato		1-16-	-2007	Goth	a, Flo	rida
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			23a. Part 1. Enter the disease, or com	plications that caused the deat	h. Do not en	ter the mode of	dying, such as	cardiac or	respiratory ai	rrest,	169 1111	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	A car Ha	Α.	1.1060	rdial	11/10	etion.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq	uence of\:	usi Eas	400an	myas	awa	J	-	
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Вох	eath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		De				23d.	Date of delive	iry
	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d		⊒Ectopic pregna ☑ Other (s <i>pecif</i> y					Month	Day Year
P.O.	thet the de sed by the a deteched t	hys	9 □ Unknown	9□ Unknown								
	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and tridicacing and the director, page 2 should be deteched for use as the burial-transit	by P	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause	given in Part	le.	23e. Did to	obacco use c	ontribute to th	e cause of death?
Records,	quire on sig uld b	Pa	Phohabile	acconole	e a	ulli	des	2are	יםו ג	Yes 2□No	3 Prob	ably 4 ⊠unknown
8	s been si should	Completed	CVAXZ.	I. (C) Sic	lod	11100	1 11001	,	24a. Was	an 24	b. Were auto	psy findings available
Re	he lav	E				vice	7.14.			rmed?	death?	npletion of cause of
tal	ician: Th certificate rector, pag	e C	25. Was case referred to medicat				26 Plan	o of Dogth	1 ☐ Yes (Check only o	2 12 No	1 🗆 Yes	2 No
of Vital	/sicials conditions	To B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Other		ie 5 Resid		Othor (Specif	4
	ding Physician: The h. After this certificate h funeral director, page		27. Manger of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?		8d. Describe			,
on	th. After	it o	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Work? 1 ☐ Yes 2 ☐]No				
Division	l or Attending efter death. Director: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b	200. Flace of injury - At hi	ome, farm, str	eet, factory, off	ice	2			imber or Rura	l Route Number,
Ö	efte Dir din b	ert	4 Homicide	building, etc. (Specif	у)				City or Tov	vn, State)		
	To the Hospitel or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Pt	ysician: To the best of my kno	wledge, deat	h occurred at th	ne time, date ar	nd place, a	nd due to the	cause(s) and	manner as st	ated.
	ne Hc n 24 l ne Fu iletely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in n	ny opinion, dea	ath occurre	d at the time,	date and place	ce, and due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	Λ		29c. Lic	ense number		_	29d. Date sig	ned (Month,	Day, Year)
			A Alusto) MD		I	39	12	- 7	.Tamıa	ry 25,	2007
	2		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type,	Print)	- (2 11		\(\)	1 ~	2001
	5		A. AMMED	MD 821	N'EL	Mais	ST 18	ball	mo	el v	410	4201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	200						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** HOWARD SHOWALTER 1309 M 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Musica Consor MARYLAND BALAMONE UNIOUNSIN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) July 13 1911 Birthplace (State or Foreign Country) **Funeral** Days 1**X**] M 2□ F 95 Yrs. PA Director 578-58-6851 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits items 23a or 28a-f ehow recinust be notified at 1 ☐ Yes 2 🔀 No Directo Severna Park Anne Arundel Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 43 W McKinsey Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 ☐ Divorced "naturel". al Hygiene. I other then "nature ivent, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrican US Government Ith and Mental Hygir 27 ie marked other r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Showalter Nellie Joseph Mae Shetrom ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train (sister) 7469 D. Furnace Branch Rd., Glen Burnie, MD 21060 Harriet C. Showalter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 Donation 5 Other (Specify) Glen Haven Cemetery 2007 Glen Burnie, Maryland 21. Signature of uneral Service Licen, ee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complifations the cased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one as seed the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PARLETA INDUPARENCHINA Pnysician /Medical Due to (or as a consequence of): Examiner Susauran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Whiknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t lirector, page 2 s performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this After the 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation JAN 24 2007 FALL From Standin death. 1 ☐ Yes 2 ☐ No MRNWG. within 24 hours after death

To the Funerel Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1201 N. Crain Hwy Glen Parin 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Glen Burnie, Mig Atrestauran To the Hospitei Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of Certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 6 2007

ear) 32 Registrar's Signature 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Examin	er	4a. Facility Name (If no	ot institution, give	street and number)			4b. Ci	y, Town, o	r Location	n of Death			c. County of		
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is I am a should be med within 7.2 hours after deafth with the marylan Leafth and Mental Hyglene. Health and Mental Hyglene. Thealth and Mental Hyglene. other traumatic event, the Medical Examiner must be notified at	Director	#W MD	JEFFERSO		KEA	RNEYVI	1	Wald	iori						¥∑Yes 2∏No
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Item	-nn	11. Marital Status 1 ☐ Never Married	2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢	⊆verin o. No	5. 13.			an, Mexic	an, Puerto F	cify Yes or N Rican, etc.)	0-		White,	
al", or	by I	3X Widowed 4[If Yes, Give Year or Dates:			1 ☐ Yes	2 ⊠ No	Specif	y:			Specify:	WHI	re.
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item 27		HELEN CORN 20a. Method of Dispos		UGHTER)	20h B						, KEAF				25430
Man 1		1 🔀 Burial 2 🖂 🤇	Cremation 3 ☐ F	emoval from State	200. T	lace of Dispo emetery, cre	natory o	r other plac	ce)			20C. I	_ocation - Ci	ty or To	wn, State
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Important: I any Injury o once.		21. Signature of Fune	mis El	Unear	-						RAL HO				
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the fu	atic	2 ☐ Accident	investigation 6 Could not be				М	10	Yes 2	□No					
n by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of inju- building, et	ury - At ho c. <i>(Specif</i> y	me, farm, str ')	eet, fact	ory, office		28	3f. Location (City or To	(Street a	nd Number te)	or Rurai	Route Number,
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To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 2[Medical Exami	sician: To the best oner: On the basis of and manner sta	f examinat	wiedge, deat tion and/or in	n occurre vestigati	ed at the tir	me, date a pinion, de	and place, a eath occurre	nd due to the d at the time	cause(, date a	s) and mann nd place, and	er as sta d due to	ated. the cause(s)
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	ŀ	30. Name and address	s of person who co	impleted cause of d	eath (Item	23a) (Type.	Print)						1100	-1	
ン		MUNDERT S	MITH, M.	D.	1207	O OLD		CENT	CER #	100	WALDOR	RF, N	MD 206	02	
Stat Registra		31. Date filed (Month,	Day, Year)	32. Registra	_		enter.	8							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 16, 2007 Month P^{M} 4:40 January Lodema Martha Stark 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Waldorf Healthcare Center Waldorf Charles 8. Date of Birth (Month, Day, Year) Aug. 28, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 1 □ M 2 K F 97 1909 Oklahoma 445-46-7641 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4140 Old Washington Road 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☒ No 3 \ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eli Sanborn Ada McCarty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16585 Prince Fredrick Road, Hughesville, MD 20637 Billy Stark/Son 20b. Place of Disposition (Name of cemetery, crematory or other page Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 1/26/07 Bartlesville, OK Cemetery 21. Sign sture of Juneral Service Licensee 22. Name and Address of Facility Neekamp-Luginbuel Funeral Home 700 S. Dewey Avenue, Bartlesville, OK 74003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final miora resulting in death) Due to (or as a consequence of): ERICARDIAL EFFUSION Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner

attending physician and for use as the burial-transit certificate be executed

signed by the a d be detached f

within 24 hours after death.

To the Funeral Director: After this certificate I

the Hospital

filled in by the

Medical

Examiner

Physician/Medical

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/Medical

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10a. State

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r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Je filed w. Je Hygiene.

es 1 and 2 should be filed w of Health and Mental Hygier f Item 27 Is marked other tt r other traumatic event, th

permit. Pages 1 Department of H Important: If Ite any Injury or ot

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate

	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
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ted	CONSEZUVE	TUELANDI	Halma		1 Yes 2 Y	rNo 3 Probably 4 Unknow
Complete					24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings availab prior to completion of cause of death? 1 □Yes 2 □ No
o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3 □ DC	T	ath <i>Check onl one</i> Home 5 ☐ Residence 6	Doug (6
ertification: T	27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Read Fraction Suicide determined	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	
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29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 16 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAULMENON CT WALDORF MD 20602 PATELMO SHVINKUMAR 102 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar



AHENDINO

DHMH 17 Rev 1/2001

Registrar

JAN 2 6 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:00 A M Muriel Kirk Smith Sills January 23, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 11502 Montgomery Court Beltsville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 99 Yrs. 215-52-8607 June 12,1907 Kansas Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a, State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Silver Spring Director Marvland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8505 Springvale Rd. 20910 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2□ No If Yes, Give Year or Dates: 1943–45 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item any injury or other traumatic event, the Medical Examina-1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: White ģ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Thomas Kirk (Unknown) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John T. Durfee / Attorney 4901 Montgomery Lane, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Jan.25,2007 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 2 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2XXNo 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Recurrent Pulmonary Embolism 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Peripheral Vascular Disease due to Atherosclerosis autopsy performed? res 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) iving 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Da npleted cause of death (Item 23a) (Type, Print) 20901 Gai J. Povar M.D.; 8700 Georgia Ave., Silver Spring, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Seem & Spark 6 2007 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Clarence Milton Schaub 2007 16:52 January. 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 215-32-5664 Director Aug. 11, 1935 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "naturel", or itame 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Harford Directo Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3010 Laurel Bush Road 21.009 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🖾 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3€ No Specify: Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within it and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant in Communications | City Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton George Schaub Bertie Bell Cullum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Heelth a Important: If Item 27 is any injury or other tras Nancy J. Schaub / Wife 3010 Laurel Bush Road, Abin don, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cokesbury U.M. Chr. Cem 1-29-07 Abingdon, Maryland 21. Signatur Fune a Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that assed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) EMPHYSEMA Physician OYBARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Exami 68760,6 Due to (or as a consequence of): Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056296 -24-2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hosapake Dr. Bel ason Birnba 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Registrar

07-00501 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jerome Shropshire State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day January 18, 2007 **Medical Examiner** 1116 hrs Jerome Roosevelt Shropshire 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center **Bel Air** Harford 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** oreign Months Days Director 415-44-7060 72 $_{1}X_{M}$ 18, 1934 Country) Tennesse Mar. 2 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits items 23a or 28a-f show ust be notified at once Maryland Harford Abingdon Yes 2 X No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 3407 Philadelphia Road 21009 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes 3 X Widowed Yes, Give Year Divorced 1 Yes 2 X No specify: Black 4 Specify ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Steel Worker Steel Fabrication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archibald (unk) Shropshire Be Ermadell (unk) Smith 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louisa R. Green / Daughter 40 Rock Glenn, Havre de Grace, Maryland 21078 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Highview Memorial Grdr 1-27-07 Fallston, Maryland Other Specify Donation 5 21. Signature of Funeral Service Licens Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland at clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro Part I. Enter the disease, or com-**Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Smoke Inhalation and Thermal Injuries Death Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? 2 Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ Yes 2 No 3 Probably 4 Unknown Completed pluods certificate has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 V No Yes 2 No fo the Hospital or Attending Physician: 25. Was case referred to medica funeral director, 26 Place of Death (Check only one) Be Other₄ this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day Year) Jan 18, 2007 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject involved in house fire 1022 hrs Natural Pending 1 Yes 2 ✔ No To the Funeral Director: the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 3407 Philadelphia Rd, Abingdon, MD (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. January 19, 2007 30. Name and address of person who completed cause of death (Item 23a) 10 Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

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2007

nnette Milford	Shr	opshire State 1- For State	or Print in Bia	Depa		Health a		Hygiene	201 Reg. No.	7 0205
Physici	an/	Registrar 1. Decedent's Name (First, Middle,La	ast)			• .		2. Date of De Month	ath	3. Time of Death
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		4a Facility Name (if not institution, g 3407 Philadelphia Road	·			Abingdon	or Location of De		4c. County of De Harford	
Funeral Director		5. Social Security Number 6. \$		(In yrs. I	ast birthday)	If Under 1 Ye Months Da		Hrs. B. Date of B	For	reign
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any		10a. State 10b. County		Oc. City,	Town or Location	n				10d Inside City Limits
Maryland 28a-f show any d at once.	ō	Maryland Harford		Ab:	ingdon					1 Yes 2 XNo
Maryl - 28a-1	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
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5-0036 led within 72 hours after bygiene other than "natural", the Medical Examiner	d by	15. Decedent's Education (Specify	only highest grade comp	oleted)	16a. Decedent		ation (Give kind e. DO NOT use		16b. Kind of Busines	
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Baltimore, permit. Pages La Department of He Important: If ite		1 Burial 2 Cremation 3	Removal from State	e G	Place of Disposit crematory or other	er place)		Date	20c. Location - City	or Town, State
t. Pag t. Pag tment rtant:	- 8	4 Donation 5 Other Specification of Fineral Service Line	y:	Hic	jhview M					, Maryland
Bal permi Depar Impo injur		Mark I from	I A					Home, P.		
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/Medical Examiner	- 1	failure. List only one cause on a Immediate Cause (Final disease	acn line. _a Smoke Inhalatio	n and T	hermal Injur	ies				Between Onset and Death
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	- 1	29a. Certifier 1 Certifying Physic one) 2 Medical Examine	cian: To the best of my er:On the basis of exam	knowledg	ge, death occurre	ed at the time, o	date and place, a	and due to the cau	se(s) and manner as st	ated
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		1/1	(0 11)				.M.E.		29d. Date signed (A January 19, 20	
		30. Name and address of person who	completed cause of de	ath (Item	23a)				10,20	
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St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signatu	re	ÿ				

		1. Decedent's Name (First, Middle, L	.ast)		Certificate of		2. Date of D			3. Time of Death
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aminer		4a. Facility Name (If not institution, g		- 1/0		n, or Location of De			County of Death	
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4	- 1	10a. State 10b. County		10c. City, Tov	vn or Location					10d. Inside City Limit
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Director		10e. Street and Number			10f. Zip Cod	9		10g. Citize	en of What Cou	intry?
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Funeral	3	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Decedent of If Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Nierto Rican, etc.)	0- 14	4. Race - Ameri Black, White,	
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To B	1	Charles Midifee S	Spivey			Azel F	rances N	ınn		
		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address (Stre	et and Number or	Rural Route Numb	er, City or T	Town, State, Zij	p Code)
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5		20a. Method of Disposition		20b. Place o	of Disposition (Name of ary, crematory or other p	place)	Date	20c. Loca	ation - City or T	own, State
once.		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			Hill Mem.		27/2007	Bal	ltimore	, Maryland
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1	3		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death		3. Time of Death
	Physic		ERIKA	O SCOBEL				JANUARY	Day Year 7 23 2007	1:30AM
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County of Death	
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-36	Director		212-44-9427	□M 200 F 92	Yrs.	Months Days	Hours Min.	Dec. 29.	1914 Ge	rmany
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Maryland	lid be lental ked lc ev	To Be	Karl Franke	2		:	Fr	ieda So	cobe1	
ary	shound N	_	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	g Address (Street	and Number or Ri		City or Town, State, Zi	o Code)
Σ	nd 2 alth a 27 le		Sunhild D. Boland	ler (Daughter)					e Maryland	
re,	s 1 a if He item othe		20a. Method of Disposition	20b. Pla	ce of Disno	sition (Name of			Oc. Location - City or T	
E	Page nt: If ry or		1 Burial 2 Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Hill	ldrest	Cemeter	y 01–	26-07 <i>I</i>	Annapolis,	Marvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Items 23a or 28a-f ehow empty injury or other traumatic event, the Madical Examiner must be nutified at once.		21. Signature of Funeral Service Licky	gee)	22	. Name and Addres	ss of Facility			
m	Depa Impo eny ii		Two So	anna 1	MS	Cully-Po	lyniak F	uneral Hon	ne P.A. a, Marylano	1 01100
4,	4		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death,	Do not ent	er the mode of dyin	g, such as cardia	or respiratory arres	t, raryrand	Approximate
	Physician		Immediate Cause (Final disease or condition			00 00 0 010	- 1			Interval Between Onset and Death
	/Medical		resulting in death)	a. ADVANCE Due to (or as a conseque	ence of):	JEINEN	11,/+			
10	Examiner		Convention to the secondarions	h						
Ç	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
	nd	Examiner	that initiated events	C						
Ö,	ficate be executed physician and is the burial-transit	Ĕ	resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	ate b hysic the b	dical		d						
9	artific ing p e as	Mec	IF FEMALE:							
9	eath certific ettending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregnancy			23d. Date of delive	,
P.O. Box	The law requires that the death certificate has been signed by the ettending loage 2 should be detached for use as	Physician/Me	1 Yes 2 No	4□Pregnant at time of dea 9□Unknown		Other (specify)			Month	Day Year
<u>с</u>	that the de ned by the e detached f	Ph		and a law of a second and a second as a second as						
Vital Records,	ires tha signed 1 be del	٥	Part II. Other significant conditions co	intributing to death but not result	ang in the ur	iderlying cause give	en in Part I.		cco use contribute to the	
Ö	w require been si should?	etec						1 ☐ Yes	2 No 3 □ Prob	ably 4 Unknown
ě	has t	Completed						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
		S						performe 1 ☐ Yes 2 %	d? death?	2 No
#	Physician: The this certificate	Be	25. Was case referred to medical examiner?					th (Check only one)		
5	Physical direction	2	1 192 5 2 140		R/Outpatient		4 Nuising n	ome 5 Residenc	ce 6 Other (Specif	15TE B LIBING
5	ding l	on	27. Manner of Death 1-✓ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	?	28d. Describe how	injury occurred	
<u>s</u>	tten deatl tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be				fes 2 □ No			
		Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
_	lospital hours a uneral		29a. Certifier 11 Certifying Phy	pipion. T. th. b. t. d						
	Hospital or Ai 24 hours after of Funeral Directed of filled in by	edical	(Check only 2 Medical Exam	iner: On the basis of examination	edge, death in and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the caus rred at the time, date	se(s) and manner as s and place, and due to	ated. the cause(s)
	To the Hospital or within 24 hours after (To the Funeral Dir completely filled in	Me	29b. Signature and title of certifier	and manner states.		29c. License	number	29d	. Date signed (Month	Dav. Year)
	do		m Sn-	20 X		7 <	7521	TA	MUARY	4 2007
	, \	-	30. Name and address of person who c	ompleted cause of death //to-	(3a) (Tuno 1	Print)	1271			,
1	1		maket News	8601 Veter	0 (17)	La Suis	= 204	nicker.	wille n	W 21108
56	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	10	7,				- 3
	Registra		JAN 2 6 2	ompleted cause of death (Item 2 SGO Veteral 32. Registrar's Signatu	3.	XXXXX				

			1 - For State Registrar	Otate of War	yland / Depa <i>Cer</i>	rtificate of L			Reg. No.	7 02058
		11	Hegistrar Decedent's Name (First, Middle, Last)	·)		tinoato c		2. Date of De	Reg. No.	3. Time of Death
	Physicia		Cynthia A. Thacker					Month January	y 18, 200	/ear
	/Medic Examin		4a. Facility Name (If not institution, give :			4b. City, Town, or	Location of De		4c. County of	
1 3	4		Fort Washington H	ospital		Fort Wa	shingto	on	Princ	e George's
	Funeral		Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year_ Months Days		lin. 8. Date of Bir (Month, Da		9. Birthplace (State or Foreign Country)
34	Director		577 - 62 - 4672]M 2 X F	55 Yrs.	World S Days	Tiodis IVI	Aug 23		aryland
	pun >		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or Lo	cation				10d. Inside City Limits
	aryla shov	<u> -</u>	MD Prince Ge							1 ☐ Yes 2√ No
	he M 8a-f otifie	Director		orge s	Fort Wash			1		
	vith ti	ä	10e. Street and Number			10f. Zip Code	,		10g. Citizen of Wh	at Country?
	s 23a	ral	2600 Brinkley Road			2074			USA	
	er de	Funeral	T. Maria Gales	12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? in, Mexican, Pu	' (Specify Yes or No Jerto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 □ Yes 2 🂢 No	Specify:		Specify:	white
Maryland 21215-0036	hour tural	pg pg	15. Decedent's Edu		160 Deced	ient's Usual Occupa	otion		16b. Kind of Busi	
က်	n 72 "na edic	Completed	(Specify only highest grade	le completed)	(Give	kind of work done of NOT use retired,	during most of (working	100. Kind of Busi	ness/industry
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7	filed Hygi ther ant, t	ပို	17. Father's Name (First, Middle, Last)		Bear			Name (First, Middle,		
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<u></u>	is 1 and 2 should of Health and Men item 27 is marke other traumatic	ဥ	19a. Informant's Name/Relationship (Tv)	rpe, Print)	19b. Mailin	a Address (Street a		Rural Route Numb	er City or Town St	tate Zin Code)
<u> </u>	id 2 sho lth and 27 is ma traum		Eloise Ewald/siste	•		g / ladioso (officer a	ina ryazibez ez	Trotal House Manib	or, only or rown, or	unk unk
ď	1 and 2 Health em 27 i		20a. Method of Disposition		20b. Place of Dispos	sition (Name of		Date	20c. Location - Ci	ity or Town. State
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	removal from State	20b. Place of Dispos cemetery, cren	natory or other place	e) :		200. 2000	ty of Town, Claro
	it. P.		4 Donation 5 10 Other (Specify)		22	Name and Address	o of English			
g	Depa Impo any i		21. Signature of Edneral Service License	Nade, Direc	tor St	ate Anato litimore,	omy Boa	rd 655 W. 201	Baltimo	re Street
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			shock or heart failure. List only or	ne cause on each line.	^	er the hiode or dying	g, such as care	diac or respiratory a	rrest,	Approximate Interval Between
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		1. Decedent's Name (First, Middle, Last)	2. Date of I	Reg. No	No.	3. Time of Death
Physicia	n.		Month Jan		3 2007	1020 a M
/Medica	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat			4c. County of Death	
Examine	r	0 - 11			,	
5 m.	-	5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of E	Birth	9. Birth	nplace (State or Foreign intry)
Funeral Director		219-40.0865 1 M 2 F 64 Yrs. Months Days Hours Min.	OC+.	19	TOUZ AIK	
	ļ	Usual Residence of Decedent				
rylan how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 □ No
a-f •	cto	MD Baltimore				/3
or 28	lre	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Co	untry?
238 238	a	6409 Craigment Road 21207		<u> </u>	USA	
er dez	ne Pu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Substituting International Control of Hispanic Origin?)	Specify Yes or I to Rican, etc.)	No-	14. Race - Amer Black, White	
036 burs after death with the Marylar rei', or items 23s or 28s-f show Examinar must be motified at	by Funeral Director	1 □ Never Married 2 Married 1 □ Yes 2 No 3 □ Widowed 4 □ Divorced Year or Dates:			Specify: Ol	ack.
ind 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23s or 28s-f show event, it a Medical Evanfrar must be retified at	g G			16b.	Kind of Business/	ACK
ind 21215-0 be filed within 72 h tal Hygiene. d other then "netur event, tra Hadical	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo	rking			•
withir rithen	E	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Counslet		8	baltimor	e City
nd 2. s filed v other to other to	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Midd			
yland be build be Mental Mental arked o attic eve	ToB	Medical Robinson Rebo	ena L	ono	ĺ	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other then "naturel; or treumatic event, tre Medical Event treumatic event, tre Medical Event		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	ural Route Nun	nber, Cit	y or Town, State, Z	ip Code)
		Leroy Toney Husband 6409 Craigment Rd.	Baltin	nore	1 MD 3	1207
a ~ ~ .		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c.	Location - City or	Town, State
Baltimor permit. Pages Department of temportant: if its		4 Donation 5 Other (Specify) Drbutus Cometery 113	27/07	B	altimore	e MD
Balti permit. Departir Imports eny inji		21. Signature of Funeral Service Licensee	no Far	iera	1 Service	>
o 83 5 8		Jew of the C. Esteller SISI Baltimore No	14.00al	PIR	: Balto.	IND SILPAT
The state of the s		23a. Part1. Enter the di∮ease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition a Cardiac Arrythmia)				20 minutes
/Medical		resulting in death) Due to (or as a consequence of):				
Examiner		Sequentially list conditions, b. and stage send decare				Zyeurs
P = .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Unit Struck Cause (Disease or injury that initiated events b. Unit Struck Cause (Or as a consequence of): Unit Cancer Cancer				
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760, te be ex ysicien a burial	caiE	cardiomegal u				5 wars
P.O. Box 68760, E. that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit		d. Carlottinage of				7000
X Certific C	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
Bo Bath	clar	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		_	Month	Day Year
Records, P.O. Box 68 The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown			_	
S. P. P. P. P. P. P. P. P. P. P. P. P. P.	V P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Di	d tobacc	o use contribute to	the cause of death?
ecords, law requires subsequents subsequents 2 should be	Ω Ω	Anemia	1[⊒ Yes	2 □ No 3 □ Pro	obably 4 Unknown
COL	Completed		24a. W		24b. Were au	topsy findings available
The law age 2	E		pe 1 Yes	topsy informed	? death?	2 □ No
	Be C	25. Was case referred to medical 26. Place of De			40	
of Vital Physicien: This certifica	10 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Re	sidence	6 □Other (Spec	cify)
Jing Ph After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describ	e how in	njury occurred	
Vision Vision Attending of the fune	atlc	2 Accident investigation M 1 Yes 2 No				
Division of Attendants of Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street Town, St	and Number or Ru ate)	ral Route Number,
Division of Vita Division of Vita pplat or Attending Physicien: ours after death. reral Director: After this certific filled in by the funeral director.						
To the Hospital within 24 hours a voithin 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.				
To the Hos within 24 h To the Fur completely	Ned	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d	Date signed (Monti	n. Dav. Year)
Son Son Tailer		Macing all the distance and the delice my DEA BC99/	1795		I aryani	23 2007
		Megnan Chedeley MD DEA BC9910	,,,	(,
2		30. Name and aldress of person who completed cause of death (Item 23a) (Type, Print) Meghan Checkley 900 South Caten Aven.	re Bal	himo	re, mb 2	1229
200		31. Date filed (Month, Day, Year) 32. Septistor's Signature			/	/
Stat Registra		JAN 2 6 2007 American M. Charles				
DHMH 17 Rev 1/200		The state of the s			3	
		ORIGINAL				

07-00623 David Isaiah The	ma	Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental I		.egible	9.	
		1- For State Certificate of Death Registrar	., g	Reg. No.	200	7 0206
Physici Medical Exami	an/	1. Decedent's Name (First, Middle, Last) David Isaiah Thamas	2. Date of D Month January	Death Day / 22, 200	Year 07	3. Time of Death 2042 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location of Dea Baltimore	ith	40	County of Death	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours M	'n /	Birth (MM/	DD/YYYY) 9. Bir Foreig Co	
tih the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Waryland Dallimöre Uindsor 10f. Zip Code 7/46 SEX hill Road 2/244			zen of What Cou	10d. Inside City Limits 1 XYes 2 No
5-0036 led within 72 hours after death with the Maryland Hygiene. other thau "uatural", or items 23a or 28a-f she the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Was Decedent Ever in U.S. 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Was Decedent of Hispanic Origin? (1 If Yes, specify Cuban, Mexican, Puer or Dates) 1 Yes 2 No 1 Yes 2 No specify:	to Rican, etc.)	No-	14. Race - Amer	ican Indian, Black, American
5-0036 fled within 72 ho Hygiene. fother than "ua the Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re 12 Y 11 Stock Working life. DO NOT use re			Ane hore	se tak
121 d be fi Tental I narked event,	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Nam 18. Mother's Nam 18. Mother's Nam 19. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	BAR	nes	, ,	Zin Code)
C1 = N = I	۲	Jerli Thomas - mother 7146 Bexhill Read -	Windso	RM	ill, md 2	1244
Ore, ges I an of Hea If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Method Communication (Name of cemetery, crematory or other place)	Date		Location - City or	
Baltim permit Pag Department Important		4 Donation 5 Other Specify: Netto CREMATORY 21 Signature of Funeral Service Licensee: Aller M. Carelland 3405 W. Frankin S	ney m.	alter	rce Fune	ext services
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot Wounds				Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): b.				
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ansit d	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
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lox 6876 leath certificate attending phy for use as the l	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify)	nancy	230	d. Date of delivery Month	Day Year
ires that the disigned by the signed by the distance of the detached it.	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				the cause of death?
Division of Vital Records, P.O. to low requires that the saler death as Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed		pe	as an itopsy informed? is 2 N	prior to death?	stopsy findings available completion of cause of
ital Rec irian: The s certificate rector, page	a	25. Was case referred to medical examiner? Hospital 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 1 Nurs				
on of Vinding Physich r: After this	P	1 Ves 2 No rospital 1 Inpatient 2 Ves ER/Outpatient 3 DOA rose 4 Nurs 27. Manner of Death 1 Natural 5 Pending Jan 22, 2007 1 1 Natural 5 Pending Pending Jan 22, 2007	28d. Descri Subject s		ury occurred	· · · · · · · · · · · · · · · · · · ·
Divisior tal or Attenc rs after death al Director: led in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	or Town	n. State)	nd Number or Ru	ral Route Number City

To the Hospita within 24 hours To the Funera completely fills

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

32. Registrar's Signature

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

O.C.M.E.

29d Date signed (Month, Day, Year) January 23, 2007

30. Name and address of person who c implified cause of death (Item 23a)

Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

OCME 2006

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23a Pt. I. II. 25 per me 9870 08/09/07dhb

Amend #1 Per Phy 6863 1/26/07 afficient of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 7 Reg. No. 1. Decedent's Name (First, Middle, Last) Odessa 2. Date of Death 3. Time of Death **Thomas** Year 200 7 Day Month **Physician** 1409 JANVARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3. Date of Birth (Month, Day, Year) 38 ocial Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Hours S. Carolina Months Days Yrs 251-56-1780 68 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show deal Examiner must be notifled at Director 1 ☐ Yes 2 No Randallstown Baltimore Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. 3618 Templar Road 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced American (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Western Elementary/Secondary (0-12) 12th College (1-4or 5+) Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sammie Lee Hall Carrie Lee Portee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Thomas/ Husband 3618 Templar Rd., Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Garrison Forest 1/19/07 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie F/H P.A. of Balto. Co. Signature of Funeral Service License 9200 Liberty Rd., Randallstown, Fait1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Liver Disease Immediate Cause (Final **Physician** deute disease or condition resulting in death) tolminan) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMIN executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes __251.No_ Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PES -000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACK THARINE 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar

			For State Registrar	State of Ma	ıryland		artment tificate			ind M		giene. Reg. No.	007	02	062
	Physici	an	Decedent's Name (First, Middle, Las	VIOLET	Ъ.	ш	LER				Date of Dea Month	ath Day	Year	3. Time	of Death
	/Medic	al	4a. Facility Name (If not institution, give		- •			Fown, or	Location o		JAN.	24,	2007 County of Deat	9:3	0 P M
	Examin	er	923 POOLE RD.	,			,		INSTI				ARROL		
	Funeral Director		5. Social Security Number 6. Sec. 216-28-9899	7. Age □M 2\\ F	75	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 1 / 1 8 /	y, Year)	Co	hplace (State ountry) YLANI	
	yland		10a. State 10b. County			Town or Lo								10d. Inside	City Limits
	e Mar	ctor	MD CARRO	LL	WES'	TMINS	STER							1 □ Ye	es 2 X No
	with th	Dire	10e. Street and Number 923 POOLE RD.				10f. Zip	Code 2115	5.7			10g. Citiz	zen of What Co	ountry?	
	death me 23	erai	11. Marital Status	12. Was Decedent E	ver in U.S	. 13.	Was Deced	ent of Hi	spanic Orio	gin? (Spe	cify Yes or No	or No- 14. Race - American Indian,			
980	be filed within 72 hours efter death with the Maryland tal Hygiene. ud other than "neturel", or iteme 23a or 28e-f ehow event, I're Medical Examinar roual be notilliad at	I by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:		AN	fYes,spec 1□Yes 2		Specify:	, Puerto F	tican, etc.)		Black, Whit		
21215-0036	ithin 72 h ie. ien "netu Medicel	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5	+)	(Give	dent's Usua kind of wor DO NOT us	k done d	uring most	of working	g	16b. Kind of Business/Industry			
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Maryland	ld be f lental f ked of ic eve	To Be	17.1 aliter 3 Hame (r II3t, Middle, Last)	HARRY A	MOS 1	DEITZ	Z				ESTEL		DELL		
lary	permit. Pages 1 and 2 should be Depertment of Health and Manta Important: if item 27 is marked eny injury or other treumatic ev ance.	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	ng Address	(Street a	nd Numbe	r or Rura	Route Numbe	er, City or	Town, State, 2	Zip Code)	
	l end i		HILTON B. UHLE	R -HUSBA		923 Ince of Dispo			.,WE		INSTER				
nor	ages int of h t: if ite y or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cer	netery, crei	natory or ot	her place					cation - City or SVILL]		
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8760,	cate be executed by sicien and the burial-transit	d													
P.O. Box 68	the death certifical y the attending phy iched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year					
	The law requires thet the death ste has been signed by the atte bage 2 should be detached for		Part II. Dther significant conditions of	ontributing to death bu	ut not resul	ting in the u	nderlying ca	ause give	on in Part I.		23e. Did t		se contribute to	the cause of	
of Vital Records,	The la ete has page 2	Completed									24a. Was autor perfo 1 \(\text{Yes} \)		death?	utopsy finding completion o	
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		210		Othe	VC-		(Check only o				
n of	ding Phys	on: To	1 Yes 2 No 27. Manney of Death 1 Watural 5 Pending	28a. Date of Injur (Month, Day	у 2	PVOutpatier 28b. Time o Injury		Bc. Injury Work	at Nu		e 5 ⊠ Resi 8d. Describe		S □Other (Spe y occurred	cify)	
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ΟĬΧ	at or At after i Direct d in by	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ory - At none. (Specify)	ne, farm, sti	eet, factory	, office		-	City or To		d Number or Ri	urai Houte N	umber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examination	ledge, deat on and/or in	h occurred a vestigation,	at the tim	e, date an	d place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause	e(s)
	withir To th	Ň	29b. Signature and title of certifier	W. Vol	- M	1		_	number	60		29d. Dat	e signed (Mont	h, Day, Year	
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	5		30. Name and address of person who Flavio houter n	72555	Sau	th C	Print)	cSt	reat	LUX	SHIN	ster	MDZ	21157	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 6 20	32 Registra	ar s signatu	10	we								

		1 - For State Registrar	•	aryland / Depa <i>Cei</i>		lealth and	•	ene 007	02063
Physic /Med		Decedent's Name (First, Middle, Lass	BERTHA	PANAYOTA	VALSAMA	KI	2. Date of Death Month	Day Year	3. Time of Death 5:37 A M
Exami		4a. Facility Name (If not institution, give Union Memorial	· ·		Balt	or Location of Deat imore		4c. County of Death	
Funeral Director		5. Social Security Number 220–12–5948 6. Security Number 220–12–5948	X 7. Ago □M 2½ F	e (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			place (State or Foreign ntry) York
Maryland	tor	10a. State 10b. County Maryland N/A		10c. City, Town or Lo	cation Baltimor	re			10d. Inside City Limits 1 X Yes 2 □ No
uth with the 23s or 28	rai Director	10e. Street and Number 600 Light	St., Apt.	. 537	10f. Zip Code	21230	10g	. Citizen of What Cou USA	ntry?
BAITIMOFE, MATYIANG 21213-UU35 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🐼 If If Yes, Give Year or Dates:	10	Was Decedent of H f Yes, specify Cubin 1 ☐ Yes 2 1 No		Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 71e marked other then "neturel", or treumetic event, tre Medical Exam	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			dent's Usual Occup kind of work done DO NOT use retired Clerk-A			b. Kind of Business/In Morgan Sta	•
VIADIO Z vuld be filed Mental Hygi nrked other ntic event, ti	To Be Co	17. Father's Name (First, Middle, Last)	thenes N	Matalas			ne (First, Middle, Ma.		J
C, Mary 1 and 2 sho Heelth and I sm 27 is ma ther treuma		19a. Informant's Name/Relationship (7) Carol J. Carr 20a. Method of Disposition	ype, Print) (Granddaug		Winthrop		nd Floor,	Staten Is. C. Location - City or To	, NY 10314
SAILIMORE, Dermit. Pages 1 ar Department of Hee mportant: if Item any Injury or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		Greek Ort	natory or other place. hodox Cei	metery 1,	/25/07 Ba	ltimore, M	aryland
D gamen		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do not ent				me P.A Md. 2123	Approximate
Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)			System	Failure			Interval Between Onset and Death 7 days
	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	Iti Organ a consequence of): chemic a consequence of): Forated	Visaus	ity			10 days
ate be executed hysicien end ine burial-transit	cal	that initiated events resulting in death) Last		a consequence of):					,,,,,,,,
The law requires that the death certificat. The law requires that the death certificat site has been signed by the ettending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	ery Day Year
n requires that the dispension of the dispension of the dispension of the should be detached	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the ur	nderlying cause giv	en in Part I.		co use contribute to the	he cause of death?
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Physicial this certi	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	Hospital:	nt 2□ER/Outpatien	t 3 DOA Oth	00	ath (Check only one) lome 5 TResidenc	e 6 ⊡Other (Specif	v)
Lor Attending Physician: after death. Director: After this certific	Certification:	27. Manney of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injun World M 1		28d. Describe how		,,
5 E E		4 Homicide determined	building, etc	iry - At home, farm, stre c. (Specify) of my knowledge, death		or day and class	City or Town, S		
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	and place, and due to	the cause(s)
To the vithin 2 To the complet	Σ	29b. Signature and title of certifier Belg	JANSKY,	M.D.	AT 24			Date signed (Month,	
A Sta	ate.	21 Date filed (Month Day Voor)	usky, M.	D. Unio	Print)			MD	
Regist	rar	JAN 2 6	2007 2	Sire Al	fort				
				ORIGI	NAL				

State of Maryland / Department of Health and Mental Hygiene 02064 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 6:00 AM M January 12, Hilda S. Wood /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Crofton Anne Arundel 1606 Farnborn Street 8. Date of Birth (Month, Day, Dec 31, 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Days Months Hours 1□M 257F Vrs 1927 79 Director 242-32-9137 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County •how r than "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Crofton MD Anne Arundel 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21114 1606 Farnborn Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 receptionist medical ages 1 and 2 should be filed a ont of Health and Mental Hygie It: if Item 27 Is marked other t y or other traumatic event, IL. other 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Caleb Bascomb Kincaid Lillian Kathleen Garrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Anderson/daughter 1606 Farnborn Street Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ott ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signalure of Funda 1 1 State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 S. Wade Director m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) 24 hours **Physician** PULMONARY EMBOLISM /Medical Due to (or as a consequence of): Examiner 2 months PARAPLEGIA DUE CO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit The law requires that the death certificate be executed 2 months TRANSVERSE MYELITIS Due to (or as a consequence of): physician a Physician/Medical SMALL CELL LUNG CARCINOMA e years as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE LUNG DISEASE, LUMBAR COMPRESSION Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No SACRAL DECUBITUS ULCER, HYPERTENSION has this certificate 1 Yes 2 No Division of Vital : After this certifical tuneral director, 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М within 24 hours effer death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 122/07 D 50872 Julsuca GOIDS BORD MEDICAL CENTER / Choptank Community HS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA P. URBAN, MD 316 RALKOAD AVENUE GOLDSBORD, MARYLAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 6 2007

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

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Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Bepartinent of Health and Mental Hygiene amend item 20b per flog864, 2-9,07e yt 02065 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 01/20/2007 2:40 a^M Yolanda Elaine Webb 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 AR 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🛛 F 0870171963 43 463-39-4536 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Howard Columbia 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 11884 New Country Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consultant Financial Consultant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sylvia Thomas Harvey Webb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Harvey E Webb / Father 9306 West 51st. Street, Merriam, KS 66203 20b. Place of Disposition (Name of cemetery, crematory of other place)
Shawnee Mission femory 01/27/2007
Crematory Carden of Facility 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 元 Removal from State Shawnee, KS 4 ☐ Donation 5 ☐ Other (Specify)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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MD

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Director

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the within 24 hours a

Division or Vital Records, P.O. Box 68760

Physician:

	Davola A-	llarshall	Charles L. Steve 1501 East Fort	ens Funeral Venue, Bal	Home Inc	Ď 21230
	shock, or heart failure. List only of Immediate Cause (Final	olications that caused the death. Do not one cause on each line. Pleural Effus	enter the mode of dying, such as cardia			Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or as a consequence of): Gastric Cance.				
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ysicial //weu	IF FEMALE: 23b. Was decedent pregnant . in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
ed by FI	Part II. Other significant conditions of	ontributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to the	he cause of death?
Solin pier				24a. Was an autopsy performed' 1 Yes 2 ▼	prior to condeath?	opsy findings available impletion of cause of
2	25. Was case referred to medical examiner?	Harris de la companya della companya della companya de la companya de la companya della companya		ath (Check only one)		
2	I les zXIIII			Home 5 ☐ Residence	6 ☐Other (Specif	<i>(y)</i>
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	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
Calcal	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, do niner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and placer investigation, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as s and place, and due to	itated. o the cause(s)
DIAI	29b. Signature and title of certifier	PHYSICIAN	29c. License number 0052 122		Date signed (Month, anuary 25,	
	30. Name and address of person who of Peta C	completed cause of death (Item 23a) (Type and Factorian - Boy				
	31. Date filed <i>Month, Day, Year)</i>	32. Registrar's Signature	soft)			

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, *Last) 2. Date of Death 3. Time of Death ELCH Month Year Physician 55 PM SAN LNGRID 2007 */Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 105PITAL BAUTIMORE FRU If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗙 F 45 Yrs Director 214-88-6961 6/8/61 Florida Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD N/A Baltimore City 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 131 W. Lee Street 21201 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) nd Mental Hygiene. marked other than Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental H Ronald Lewis Brown Regine Barthelemy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun Charles F. Welch, Jr. /Husband 131 W. Lee Street, Baltimore MD 21201 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ Removal from State Bayview Crematory 1/27/2007 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Jr. Charles L. Stevens Funeral Home
1501 E. Fort Ave, Baltimore MD Signature of Funeral Service Licensee Stevens Funeral Home, Victor P. Doda, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between tepatition Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for deig consequence off siclan and burial-transit be executed Due to (or as a consequence of) Box 68760, physician a Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. has been signed by the age 2 should be detached in 9 Unknown 9 Unknown resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1⊟ Yes 2 **4** No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred r Attending P er death. Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or / To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-12634 N23, Z007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

2007

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32. Segistrar's Signature

		_1	For Stata Registrar			partment of F ertificate of		R	ag. No.	3, Time of Death		
	Physicia		1. Decedent's Name (First, Mid					2. Date of Dea Month	Day Ye	ar		
	/Medic	al .		Homas war		4h Cin Tourn	r Location of Death	01	4c. County of D			
	Examin	er '	la. Facility Name (If not institut	medical cente		Baltin			40. Oddiny of E			
	5		5. Social Security Number		ge (In yrs. last birthd 76		If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign		
	Funeral Director		212-28-5639	1 ™ M 2□F	76 _{Yrs}	Months Days	Hours Min.	09/11	/1930 MD	Country)		
	ס	-	Usual Residence of Decedent		100 City Town	of anation				10d. Inside City Limits		
	anylar	.	10a, State 10b. Cour	nty	Baltimo					Laryes 2 □ No		
	Se-f	ecto			Darcino	10f. Zip Code	<u></u>		10g. Citizen of Wha	t Country?		
	with ti		10e. Street and Number 3838 Roland Av	venue Apt. 130	06	21211			USA	,		
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortent: If item 27 Is marked other then "natural", or Itams 23a or 28e-f show ortent: If item 27 Is marked other then "natural", or Itams 23a or 28e-f show injury or other traumatic event, I'm M. Jical Examination and illing at the M. Jical Examination and illing at the M. Jical Examination and Itams are set to the M. Jical Examination and Itams are set to the M. Jical Examination and Itams are set to the M. Jical Examination and J. Jical Examinati	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 □ Widowed 4 ➡Divorc	12. Was Deceden Armed Forces 1 [74]Yes 2 □ If Yes. Give	t Ever in U.S. 1	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Specify:	ocity Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. White		
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and	be find Hed off	Be c	 Father's Name (First, Midd John Spano 	ile, Last)			Catherine					
Maryland 2121 nd 2 should be filed within sith and Mental Hygiene. 27 Is marked other then " r traumatic event, I'm Mar		To	19a. Informant's Name/Relation Kathleen Lensch		19b. M 231	Mailing Address (Street	and Number or Rura Avenue B	A Route Numbe	r, City or Town, Sta e, MD 212	te, Zip Code) 114		
Baltimore,	Pages 1 and 2 ent of Health a nt: If item 27 ls ry or other trai	15	20a. Method of Disposition 1 ☐ Burial 2 ☑ Crematic 4 ☐ Donation 5 ☐ Other	on 3 □Removal from State r (Specify)	cemetery,	isposition (Name of crematory or other place ake Cremat		Jan 23 2007	20c. Location - Cit Beltsville	y or Town, State a, Maryland		
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				, or complications that cause List only one cause on each	ed the death. Do not line.	t enter the mode of dyi	ng, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
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ord	w require been sign	ted	Acute renal	tailure				1	Yes 2. INo 3[□ Probably 4 □Unknown		
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/ita	ician: The certificate ector, pag	Be	25. Was case referred to med examiner?				26. Place of Deat					
≥f \	Physician: this certificantal director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa		atient 3 DOA			dence 6 Other	(Specify)		
			27. Manner of Death 1 ☑Natural 5 ☐ Pe	riulity	njury 28b. Tir Da <i>y Year)</i> Inji	ury Wi	ury at ork? □ Yes 2 □ No	Zou. Describe	now injury occurred			
Division	I or Attendi after death. Director: A	rtificat	3 ☐ Suicide 6 ☐ Co	puld not be termined 28e. Place of building,	Injury - At home, farn etc. (Specify)	n, street, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical Certification;	29a. Certifier 1 Cert (Check only one)	ifying Physician: To the be ical Examiner: On the basis and manner	of examination and	death occurred at the for investigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)		
	o the ithin 2 o the omple	Mec	29b. Signature and title of ce			29c. Licer	nse number		29d. Date signed (Month, Day, Year)		
	F 3 F 8			below, MD		AUGI	76435517	543	1/22/	2007		
	7X				of death (Item 23a) (T				311			
		ate	31. Date filed (Month, Day, Y	SCITABECMAN (ear) 6 2007 32. Fgi	strar's Signature	books						
43	Regist	rar	JAN 4	3 0 -0	all an a s. s	-						

07-00502 Donald Terrean	ce A		or Print in Black Inde						
		1- For State Registrar		icate of Death				7 0206	
Physici		Decedent's Name (First, Middle, L.	,			Reg. 2. Date of Death Month Death		3. Time of Death	
Medical Exami	ner	Donald Terrea 4a. Facility Name (if not institution,	nce Author White	At On T		January 18,		1048 hrs	
		3407 Philadelphia Road	give street and number)	Abingo	wn, or Location of Dea Ion	ıtn	4c. County of Death Harford		
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last b				MM/DD/YYYY) 9 Birt		
Director			X M 2 F 4	Yrs. Months	Days Hours M	May 28,	2002 Foreig	maryland	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location				10d Inside City Limits	
*	'n	Maryland Harfor	d Abir	ıqdon				1 Yes 2 X No	
ith the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number	- 101	10f. Zip (Code	10g.	Citizen of What Cour	itry?	
th the l	اق	3407 Philadel	phia Road	210			SA		
ath wif	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent If Yes, specify	of Hispanic Origin? (§ Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,	
fter de			1 Yes 2 No	1 Yes 21x	No specify:		Specify: B1	.ack	
nours a	ed by	15. Decedent's Education (Specify	only highest grade completed) 16	a. Decedent's Usual O		work done 16	b. Kind of Business/Ir		
36 iin 72 l han "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	dailing most of work	ng me. DO NOT use te	alled)			
21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica	E S	0 17. Father's Name (First, Middle, La	st)		18.Mother's Nam	ne (First, Middle, Maio	den Surname)		
1215 be file ental H irked o	BB	Donald Andrew 1			Shaune	tte D'Ligh	nt Shropsh	ire	
D 21 should and Me 7 is ma	입	19a. Informant's Name/Relationship		9b. Mailing Address					
e, MD and 2 sho lealth and tem 27 is traumati		Shaunette Shropsl 20a. Method of Disposition		40 Rock Gl e of Disposition (Name	enn, Havre		, Maryland Oc. Location - City or		
nore		1 X Burial 2 Cremation :	Removal from State crem	atory or other place) view Memor		1	•	·	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Speci 21 Signature of Funeral Service Lic			ddress of Facility Funeral H		Fallston,	Maryland	
- 3		Milall my		1317 Co.	kesbury Ro	ad, Abingo	don, Maryl	and 21009	
Physician /Medical		failure. List only one cause on			dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and	
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Smoke Inhalation and The Due to (or as a consequence of):	rmal Injuries				Death	
Shappy and	U	Sequentially list conditions,	b						
	j.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):						
- e .c.	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):						
execute	_	UNPENDED	dAMENDED						
60, ate be a hysicie e buria	Physician/Medica	IF FEMALE:	23c. If yes, outcome of pregnance				22d Date of delivery		
Box 68760 e death certificate b the attending physi ed for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 Ectopic pregn		23d Date of delivery Month D	ay Year	
30x death of	ysic	1 Yes 2 No 9 Unknow	4 Pregnant at time of death 9 Unknown	5 Other (Specify	1)				
O. E at the d by th	됩	Part II. Other significant conditions	s contributing to death but not result	ing in the underlying ca	ause given in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?	
S, P	ed by					1 Yes 2	✓ No 3 Proba	ably 4 Unknown	
Records, P.O. The law requires that the cate has been signed by t page 2 should be deached.	plet					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of	
Rec The la	Completed					performed 1 Yes 2 ✓		2 No	
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be executed ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit	a	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/		Place of Death (Check				
of V ig Physical regard di	٢	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury 28b	Outpatient 3 DO/ . Time of Injury 286	. Injury at Work?	28d. Describe how		Scene	
ion ttendin leath. for: A	ertification:	1 Natural 5 Pending 2 Accident Investiga		22 hrs	Yes 2 V No	No Subject involved in house fire			
Divisior pital or Attend ours after death eral Director: filled in by the	ţįĮ;	3 Suicide 6 Could no	at be 28e. Place of Injury - At home,	farm, street, factory, o	ffice building, etc.	28f. Location (Street or Town, State)		al Route Number, City	
pita cours	ē	4 Homicide determin	(Specify) Single Family			3407 Philadelphia	Road, Abingdon,	MD	

29a. Certifie (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 19, 2007 e lissa 30. N me and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD 31 Date filed (Month, Day, Year) JAN 2 6

Assistant Medical Examiner 32 Registrar's Signature

State Registrar

07-00510 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Derrick Dana White 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician. 2045 hrs **Medical Examiner** January 18, 2007 Derrick Dana White 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Abingdon Harford 3407 Philadelphia Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director $_{1}X_{M}$ Maryland 2 24 2003 2-69-8533 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 XNo 28a-f shov or items 23a or 28a-f shorenest be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ones. Maryland Harford Abingdon Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3407 Philadelphia Road 21009 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year 1 Yes 2 X No specify: Black Widowed 4 Divorced Specify: 2 or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Andrew White, Jr. Be Shaunette D'Light Shropshire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaunette Shropshire / Mother 40 Rock Glenn, Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 crematory or other place) Cremation 3 Removal from Stat Highview Memorial Grdn 1-27-07 Fallston, Maryland Donation 5 Other Specify 22. Name and Address of Facility Home, 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval 23a. Part I. Enter the disease, or comthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Smoke Inhalation and Thermal Injuries Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED AMENDED e attending physician for use as the burial 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed Be After 2 Certification: the

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: filled in by within 24 hours a To the Funeral

U					Tes Z	No 3 Probably 4 Uliknown				
10 <u></u>	·				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical				of Death (Check	only one)					
examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursin	ng Home 5 Resid	ence 6 Other: Scene				
27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injur	y at Work?		28d. Describe how injury occurred				
1 Natural 5 Pending	Jan 18, 2007	1022 hrs	1 Y	es 2 🗸 No	Subject involved in house fire					
2 🗸 Accident Investigation		form stored foots		illian ata	OOF Leasting (Chant	and Number of Dural Pouts Number City				
3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, tarm, street, tacto	ory, office b	Jilaing, etc.	or Town, State)	f. Location (Street and Number or Rural Route Number, City				
4 Homicide determined	(Specify) Single Fan	nily			3407 Philadelphia F	Road, Abingdon, Md.				
one) 2 Medical Examiner: C	On the basis of examination a and manner stated.	nd/or investigation, in	my opinion,	death occurred	at the time, date and pl	ace, and due to the cause(s)				
29b. Signature and title of certifier	•	2	29c. License	number	29d.	Date signed (Month, Day, Year)				

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Year

January 19, 2007

State Registra

Medical

Name and address of person who completed cause of death (Item 23a)

2007

Year)

Melissa Brassell, MD

31. Date filed (Mc

Assistant Medical Examiner

College.

32. Registrar's Signature

			1 - For State Registrar	State of I	Marylar	-			ealth a	and M		giene Reg. No.	007	02070
	Dhysici		Decedent's Name (First, Middle, Li	ast)							2. Date of Dea Month	ath Day	Year	3. Time of Death
al a	Physici /Medi		Sui-Ching Yang								January		2007	10:00PM M
d	Examir		4a. Facility Name (If not institution, gi	ve street and number	er)		4b. City	, Town, or	Location of	of Death		4c. Co	ounty of Deet	th
			Suburban Hospita					thesd					gomer	
	Funeral Director			Sex 7. 1⊠M 2□F	Age (In yrs. 89	last birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day Jan. 5,	h v. Year) 1918		thplace (State or Foreign buntry) .Wan
	and wo		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary	jo	Maryland Montgom	nery	Pot	omac								1 ☐ Yes 2 No
	128a	rec	10e. Street and Number				10f. Zi	p Code				10g. Citizer	of What Co	l
	3a o	Funeral Director	9013 Congressiona	1 Ct.			20	0854				Taiwa	ın	
	deat	ner	11. Marital Status	12. Was Decede			Was Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No-	14.	Race - Ame	
9	or its	F	1 Never Married 2 Married	1 Yes 21				-	Specify:	i, rueno	Rican, etc.)		Black, White Becify: AS	
ğ	ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	s:			2,00110	Specify.			34	ecily: A3	Lan
21215-0036	nett dice	Completed	15. Decedent's E (Specify only highest gi			16a. Dece (Give	kind of w	ork done o	lurina mosi	t of workii	ng	16b. Kind	of Business/	Industry
7	than than	E C	Elementary/Secondary (0-12)	College (1-40	or 5+)		DO NOT)			T-0 04424		
0 0	2 should be filed within 72 hours after death with the Maryland and Mentat Hygiene. Is marked other than "natural", or Itame 23s or 28s-f show aumatic event, the Medical Exactions must be nutified at		17. Father's Name (First, Middle, Las			Accou	ntani	<u>-</u>	18. Mothe	r's Name	(First, Middle,	Insur		
Maryland	d be entai	To Be	Han Yang							Chai				
<u> </u>	Shoul nd Ma mari	F	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailie	na Addres	s (Street a			l Route Numbe	r. City or To	own State Z	Zin Code)
2	ath a		Charles Young (s	on)			-				Potomac			
re,	r Hear		20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	me of	1		ate		ion - City or	
e E	Page ent o nt: If ry or		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Speci			ego Pi ererv				eb.3	,2007	ake O	CMAGO	, Oregon
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "naturat", or iteme 23e or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be nutified at ance.		21. Signature of Funeral Service Lice		Cem	erery	2. Name a	nd Addres			aine Fu			, oregon
m	Depa Impo eny ir	1	Diana Z	Jowner	-1						t. Alex			. 22314
)	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that cay one cause on each	sed the dear	nonavy			g, such as	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed a eltending physician and of for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Salver	e Chr	uniq, i	obstance	heph	lmanny	8 months 8 months 8 months				
Ö.	the death certific y the attending p ached for use as i	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	ne of pregna 2 Feta t at time of o	ancy al death 3	□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Yea		
rds, P.	The law requires that the de- ste has been signed by the a page 2 should be detached to		Part II. Other significant conditions Congostive Heart			_	nderlying (cause give	n in Part I.		III	bacco use		the cause of death?
Division of Vital Records,	Physician: The law r r this certificate has be iral director, page 2 sh	Completed	Atrial fibrillation,	Anomia							24a. Was a autop: perfor 1 Yes	sy	prior to death?	topsy findings available completion of cause of
/112	Physician: this certifica ral director, p	Be (25. Was case referred to medical examiner?	Name in A							(Check only or	10)		
5	this c	2	1 ☐ Yes 2 X No	Hospital:		ER/Outpatier		DA Othe	r: 4 Nu	rsing Hon	ne 5 Resid	ence 6	Other (Spec	cify)
Sion	il or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ın	njury Day Year)	28b. Time of Injury	M	28c. Injury Work 1 🔲 \	at ? ′es 2 □ h		8d. Describe h	ow injury or	ccurred	
Ö	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		3 Suicide 6 Could not be determined	building,	etc. (Specil	fy)					City or Tow	n, State)		ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical	29a. Certifying Pl (Check only one) Certifying Pl 2 Medical Exa	hysician: To the be miner: On the basis and manner	st of my kno s of examina stated.	owledge, death	occurred vestigation	at the tim	e, date and inion, deat	d place, a h occurre	nd due to the c ed at the time, d	ause(s) and late and pla	d manner as ice, and due	stated. to the cause(s)
	To To I	Σ	29b. Signature and title of certifier					c. License					gned (Month	n, Day, Year)
			CHIN CHURN-HE	u, mD			I	2000	54-21	-		Janu	m 24	, 2007
	12		30. Name and address of person who	completed cause o	death (Iter	п 23a) (Туре, Он ееуь	Print)	cal:	#215	Rive	erdale,	mD2	0737	
8	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 2 6	2007 32. Revii	strar's Signa	ature	canti	1						

			For State Registrar	State o	of Marylan		artment of rtificate of				giene Reg. No.	2007	02071
			Decedent's Name (First, Middle,	Last)						2. Date of Dea	Date of Death 3. Time of		
	Physicia		Elizabeth Hele	n Altoba	11:					Month Januar	Day		11:40Å
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Locati	on of Death	Januar		County of Death	11:40A
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	Funeral			S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Un	der 24 Hrs.	8. Date of Birt	th V Yoorl	9. Birth	place (State or Foreign
ě.	Director		146-30-7005	1□M 2☐F	67	Yrs.	Months Days	Hou	rs Min.	(Month, Day NOVEMBER		1	JERSEY
	σ		Usual Residence of Decedent							1			
	ylan how at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	a-fs	턍	MARYLAND MONTGO	MERY			SILVER	SPRI	NG				1 ☐ Yes 2 💢 No
	h the	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Cou	untry?
	th wil		15127 VANTAGE HI	LL ROAD				20905				U.S.A.	
	dea ems	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic	Origin? (Sp	ecify Yes or No-	-	14. Race - Amer Black, White	
9	after or ite mine		1 ☐ Never Married 2 ☐ Marrie		2 X No		1 □ Yes 2 ☒ N			110011, 0101,			
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7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at		12	4)		l	DECORATO	_	othor's Nom	a /First Middle		OURON PAIN	TS
in d	be fi	æ	17. Father's Name (First, Middle, La					10.10	ourier's marii	e (First, Middle,	iviaiden	Surname)	
Ž	ould I Mer narke	은	FRANK BRACHER,			1				ERINE SON			
Maryland	12 st h and 7 Is n		19a. Informant's Name/Relationshi				ng Address (Stree					•	
ď.	1 and Healt Pm 2		LOUIS ALTOBELLI 20a. Method of Disposition	- HUSBAND	20h F		27 VANTAGE sition (Name of	HILL		SILVER SP Date		MARYLAND ecation - City or	
ō	it of h		1 ☑ Burial 2 ☐ Cremation	3 □Removal from	State	cemetery, crei	matory or other p	-	-		200. Lu	Cation - City or	Town, State
Ħ	t. Pa tmer tant: njury		4 □ Donation 5 □ Other (Spe		GA'		AVEN CEME		1/12	/2007	SILV	ER SPRING	, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee	L	H	2. Name and Add IINES-RINA	LDI FU	JNERAL I				
	TO = 10 O		Migelin (varce	0							PRING, MA	RYLAND 20904
П			23a. Part1. Enter the disease, or c shock, or heart failure. List o	nly one cause on	caus <i>e</i> d the deat each line.	n. Do not ent	er the mode of d	ying, sucr	n as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. RE	SPIRATORY	FAILURE							1 MONTH
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):							
ß,	_xao.	Ļ	Sequentially list conditions,	D	IMARY PER		CARCINOMA						1½ YEARS
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D03.00	Marke off:								
	ecut and I-tran	хап	that initiated events c. Due to (or as a consequence of):										
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87	cate physi	dical	`	d									
9 ×	that the death certificed by the attending podetached for use as	0 1	IF FEMALE:	29c If yes ou	itcome pf pregna	ancy							8 -
Вох	ath cath	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 Feta	al death 3[Ectopic pregnar	псу			1 2	23d. Date of deli Month	very Day Year
o.	the a	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□Unkr	nant at time of c nown	Jean 5L	Other (specify)						
Ω.	that the		Part II. Other significant condition	is contributing to c	death but not res	ulting in the u	nderlying cause o	iven in P	art I.	23e. Did to	obacco u	use contribute to	the cause of death?
Records,	The law requires that the death certifitate has been signed by the attending bage 2 should be detached for use as	Completed by	RESTRICTIVE LUNG	G DISEASE		-				10'	Yes 2	X No 3 □ Pro	obably 4 Unknown
ŏ	requestions to the contract of	etec								04- 141		0.41. 114	
ž	has law	d d								24a. Was autor	an psy ormed?	prior to c	topsy findings available ompletion of cause of
<u></u>										1□ Yes	2 🔯 No	1 ☐ Yes	2□ No
Vital	Physiclan: The rathic certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			_ [c	thor:		h (Check only o			
ō	Phys this al dir	70	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatier 28b. Time o	" OLI DOX	4 L		ome 5 X Residence 1 28d. Describe I		6 Other (Spec	sify)
L C	ding 	io	1 X Natural 5 ☐ Pending	(Moi	nth, Day Year)	Injury	W	ork? ☐ Yes 2		zou. Describe i	now injui	y occurred	
Si	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could no	ot be	e of injury . At h	ome farm str	reet, factory, offic		- 140	28f Location (Stroot an	nd Number or Pu	ral Route Number,
Division or	or Attendatter deatt Director: in by the	Certification:	4 ☐ Homicide determin	ed build	ding, etc. (Special	fy)	out, lactory, onle			City or To			rai riodie Nambei,
_	Hospital 24 hours a Funeral tely filled		29a, Certifier 1 ☑ Certifying	Physiclan: To th	e best of mv knr	owledge, deat	h occurred at the	time, dat	e and place	and due to the	cause(s)) and manner as	stated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the ompletely filled in by the funeral	Medical	(Check only one)	xaminer: On the I	basis of examina nner stated.	ation and/or in	vestigation, in m	y opinion,	death occur	rred at the time,	date and	d place, and due	to the cause(s)
	To the within 2 To the somple	Me	29b. Signature and title of certifier	1			29c. Lice	nse numb	per		29d. Dat	te signed (Month	n, Day, Year)
			1	1/	00.		D359	996				ARY 10, 20	
•	5 5		30. Name and address of person w	the completed car	ise of death /lto	n 23a) (Tuno					0211101	10, 21	
			LINDA M. BURRELL		·		·	WHEAT	ON MAT	STLAND 200	902		
	Sta	ite	31. Date filed (Month, Day, Year)	32.	aistrar's Signa	ature	1455 III	mual	CIT, FIRST	TEMPLE ZU	702		
	Regist		JAN 11	2007	Beeve !	K A	and of						

			For State Registrar	ate of Maryland / Dep <i>Ce</i>	partment of He ertificate of D		_	ene2 () () 7	02072
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia		Mitchell R. Bro	our Sr			Month January	Day Year 4 2007	2314 M
	/Medic Examin		4a. Fecility Name (If not institution, give street		4b. City, Town, or		January	4c. County of Dea	
			12714 Whiteholm	Court	Uppe	er Marlbo	ro	Prince	George's
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday			8. Date of Birth (Month, Day,)		rthplace (State or Foreign ountry)
	Director	ļ	439-14-9362 1 ¹ XM	85 Yrs.	Working Days				uisiana
	pug *		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation				10d. Inside City Limits
	faryle	ក							1 X Yes 2 No
	28a-1	Director	Maryland Prince Geor	ge's	10f. Zip Code	<u>per Marlb</u>		g. Citizen of What C	
	with with		12714 Whiteholm Co	a+	Tot. Zip code	20774	100		
	na 23	Funerai			. Was Decedent of His		city Yes or No-	14. Race - Am	States encan Indian.
-0030	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Depertment of Heeth and Mental Hygiene. Important: if time 27 is marked other than "natural; or itema 23a or 28a-f ahow any injury or other traumatic avant, the Madical Examinar must be notified at once.	by Fun	1 Never Married 2 Married 1	med Forces?	. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ▼ No	n, Mexican, Puèrto F Specify:	Rican, etc.)	Black, Whi	
5	2 ho	Completed	15. Decedent's Education	16a. Dec	edent's Usual Occupa	tion	16	6b. Kind of Business	s/Industry
<u> </u>	thin 7	ple	(Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	re kind of work done do DO NOT use retired)	uring most of workin	ng		
V	gien er th	TO.	12th		Engineer	r(Elec.)		Gover	nment
2	d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
ya Ya	Men Men arke	2	Mitchell Brown				He1e	na Barnar	by
מב	12 should be filed vogen and Mental Hygie file marked other traumatic avant, III		19a. Informant's Name/Relationship (Type, F		ling Address (Street a	nd Number or Rural	Route Number, (City or Town, State,	Zip Code)
2 0	os 1 end 2 of Heelth itam 27 i		Mitchell R. Brown		2714 Whiteh				
0	t of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remove	20b. Place of Disp cemetery, cri	ematory owner of	Park	ate 20	Oc. Location - City or	r Town, State
aitimor	tmen tant:	1	4 □ Donation 5 □ Other (Specify)		National N			Laurel,	
a D	Depermit Depermit Import any in		21. Signatule of Funeral Service Licensee	X	22. Name and Address			uneral Ho	
_	40244		23a. Part1. Enter the disease, or complication	wow I		nning Rd.		sh., DC 2	
			shock, phheart failure. List only one ca	use on each line.	nter the mode of dying	, such as cardiac or	r respiratory arres	51,	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardiopulmonar	y Arrest				Minutes
	Examiner			Due to (or as a consequence of):	_				
		ē	Sayunflaty is conditions if any, leading to immediate cause. Enter Underlying	Aspiration Pne Due to (or as a consequence of):	umonia				Days
	ansit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events	Recurrent Hear	t Failure				Davis
2	exec an and rial-tra	Examiner	resulting in death) Last	Due to (or as a consequence of):					Days
09/90	icate be executed physicien and s the burial-transit	edicai	d						
_	nd ph as th	Jed	IS SEMALE.					The very	
Ď.	res that the death certifigned by the attending be detached for use a	Physician/M	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	olivery Day Year
 T	requires that the een signed by th hould be detache	by PI	Part II. Other significant conditions contribu	ting to death but not resulting in the	underlying cause give	n in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
ecords,	w require been sig should b						1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
ည	¥ 0 0	Completed					24a. Was an	24b. Were a	utopsy findings available
	The The page	E					autopsy performe 1 ☐ Yes 2%	ed? death?	completion of cause of
	lan: rrtifice ctor, p	Bec	25. Was case referred to medical examiner?			26. Place of Death	The second second		3 20110
>	Physician: The la r this certificete hes ral director, page 2	10	1 ☐ Yes 2 № No	tal: 1 ☐ Inpatient 2 ☐ EP/Outpatio	ent 3 DOA Othe	r: 4 Nursing Hom	ne 5 🖫 Residen	ice 6 □Other (Spe	əcify)
0 0 0	nding Path. sth. r: After ti e funera	ation:	27. Manner of Death 1	ta. Date of Injury 28b. Time (Month, Day Year) 1njury	of 28c. Injury Work	at 2 ? ′es 2 □ No	8d. Describe how	v injury occurred	
DIVISION	To the Hospital or Attanding I within 24 hours after deeth. To tha Funaral Diractor: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	se. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	2	8f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
	A Hospit 24 hours Funara etely fille	edical (Check only 2 Medical Examiner;	n: To the best of my knowledge, dea On the basis of examination and/or and manner stated.	ath occurred at the time investigation, in my op-	e, date and place, a inion, death occurre	nd due to the cau	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and little of dertifier	1. Mars	29c. License	number	290	d. Date signed (Mon	th, Day, Year)
	7) Venso	The Man	MD	2543	4	1/11/0	7
2	(20)		30. Name and address of person who completed Joseph Chisholm		ng St., NW	#2000,	Wash., D	C 20010	
L	Sta Registr		JAN 1 2 2007	32. Registrar's Signature				27 1000	

State of Maryland / Department of Health and Mental Hygiene

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-	Change	-		4.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** JOHN Jan. 21, 2007 8:00 AM KENNETH BUSH /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 2841 Forge Hill Road Bel Harford Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/17/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days Min 179-20-9074 Yrs. Maryland 86 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Director MD. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2841 Forge Hill Road 21015 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Harford County Elementary/Secondary (0-12) College (1-4or 5+) 0 Supervisor Highways Dept. . Pages 1 and 2 should be filed witnest of Health and Mental Hygie tant: If item 27 is marked other tigury or other traumatic event, ID. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Delmer Bush Minnie Belle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Annie M. Walker/Daughter 2841 Forge Hill Rd. Bel Air, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. William Watters Cem 1/23/2007 Jarrettsville.Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Lifer/see 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT **Physician** OVER 24BR /Medical Examiner MYOCARDIAL INPARCITION OVER 6 HOLTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical the 93 IF FEMALE: US9 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the at id be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy 1 Yes 2 No 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Tes 2 No 2 Accident the Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DØØ 16 389 JANUARY 22, 2007 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of PALLSTON MD 21047 SUITE 105 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1-16-07 State of Marylar 1-State Registrar Amend#16a.PerFHPGCcr State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day ам Omar Rah 9:07 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-29-5178 50 Director 6/27/1956 Banjul, Gambia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notifled at 10d. Inside City Limits 1 ☐ Yes 2 X No Director Md. Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "..." any Injury or other traumatin. 20744 1902 Valley View Dr. Gambia Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No þ Specify: Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Md. Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Momodou Bah Amie Loum P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine J. Bah/ wife 1902 Valley View Dr., Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State George Washington: 1/12/07 Adelphi, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC 20011 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Leukemia weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diocace or injury that initiated events) Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy 1☐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No P 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Certification: 28¢. 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tifle of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0061887 1/9/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Ira Y.

31. Date filed (Month, Day, JAN 12

Rabin

32. Registrar's Signatur

1500 Forest Glen Rd., Silver Spring, Md. 20910

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** рМ January 2, Geneva Butler 2007 6:26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Director 578-60-9435 60 19, 1946 Washington, D.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Maryland Prince Georges Director Capitol Heights 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1408 Opus Ave. 20743 Pages 1 and 2 should be filed within 72 hours after death v nent of Héalth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 ☑ No Yes, Give 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. Jones Claice Portter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valencia Jones / Daughter 1408 Opus Ave. Capitol Heights, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Jan.10,2007 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligansee 22. Name and Address of Facility Alexander S. Pope. P.A. 5538 Mariboro Pike/Forestville, Md Part : Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Carcinoma Melastatic /Medical Due to (or as a consequence of): Examiner Chronic Lena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Hormia bunal-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate 2 No 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064801 03 107 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhann Idel M.D. 7501 Surratts Rd. Suite 307 Clinton, Md. 20735 31. Date filed (Month, Day, Year, 32. Registrar's Signatur State JAN 1 1 2007 Registrar

		1 - For State Registrar	State of Maryland	-	artment of H tificate of L		Mental	Hygiene Reg. Ne	211117	02076			
Physic	ian	Decedent's Name (First, Middle, Last) ODT C	BLAKE					of Death NUARY	^{1y} 5 2 00 7	3. Time of Death 1:15 P M			
/Med Exami	ical	DORIS 4a. Facility Name (If not institution, give s 12611 KORNETT LA	treet and number)		4b. City, Town, or BOWIH				. County of Death				
Funera Director		5. Social Security Number 6. Sex		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	n. (Mon	of Birth th, Day, Year I 16 19	Co.	nplace (State or Foreign Intry) YLAND			
Maryland a-f show	ctor	Usual Residence of Decedent	,	Town or Lo	cation	·				10d. Inside City Limits 1X Yes 2 □ No			
vith the	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic svent, trainfacture examinar master celling an any notes.	by Funeral	12611 KORNETT LANE 11. Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		207. Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 ☒ No		(Specify Yes erto Rican, et	or No-	No- 14. Race - American Indian, Black, White, etc. Specify: BLACK				
oe filed within 72 hours af all Hygiene. I dother then "neturel", or wont, ire Medice Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. i	dent's Usual Occup kind of work done o DO NOT use retired	during most of a	vorking		Kind of Business/	ndustry			
Waryiand Z nd 2 should be filed lith and Mental Hygi 27 is marked other r traumatic svent, II	To Be Co	17. Father's Name (First, Middle, Last) JOSEPH BLAKE				18. Mother's MAGGIE		Middle, Maide					
2 short and he ma		19a. Informant's Name/Relationship (Ty			ng Address (Street								
Daltimore, in permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other trees.	DONALDA LOVELACE/REPRESENTATIVE 3010 LOTTSFORD VISTA RD MIT 20a. Method of Disposition 1 \(\times \) Burial 2 \(\times \) Cremation 3 \(\times \) Removal from State 4 \(\times \) Donation 5 \(\times \) Other (Specify) Donation 5 \(\times \) Other (Specify) Donation 5 \(\times \) Other (Specify)								20c. Location - City or Town, State				
permit. P Departme Importen any injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785											
Physiciar		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. the cause on each line. DEMENTIA	Do not ent	er the mode of dyin	g, such as card	liac or respira	itory arrest,		Approximate Interval Between Onset and Death			
taw requires that the death certificate be executed that the death certificate be executed to the steed of the attending physicien and the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the burial-transit to the steed for use as the steed for u	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence FAILURE TO Due to (or as a consequence to (or as	THRIV	/E								
It the death certification by the attending precise as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3[Ectopic pregnancy Other (specify)	1			23d. Date of del Month	very Day Year			
quires that the n signed by the	þ	Part II. Other significant conditions con DIABETES MELLITUS		lting in the u	inderlying cause giv	en in Part I.	236			the cause of death?			
The The ete h	Completed			-	<u>.</u>			Was an autopsy performed?	death?	topsy findings available completion of cause of			
OI VILAI Physician: T this certificet ral director, pa	8	25. Was case referred to medical examiner?	Hospital:		- 25 DOA O#	26. Place of							
ding Physi h. After this of funeral dir	tion: To	1 译Yes 2 No 27. Manner of Death 1 營Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	R/Outpatie 28b. Time o Injury	of 28c. Injur	4 Nuisin		Residence scribe how inj	6 ☐Other (Spe jury occurred	cify)			
UIVISION OT el or Attending Phy s efter death. il Director: After this ed in by the funeral d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,		reet, factory, office			ation (Street a or Town, Sta		ıral Route Number,			
To the Hospitel or At within 24 hours effer of To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Exemi	sicien: To the best of my know ner: On the basis of examinati and manner stated.	vledge, deat on and/or in	nvestigation, in my o	ppinion, death o	ace, and due ccurred at the	time, date a	nd place, and due	to the cause(s)			
To the within 2 To the complet	Σ	29b. Signature and title of certifier	Sen O		29c. Licens	DZZ7	po	29d. D	Date signed (Month, Day, Year)				
e (4)		PETER SCHISSLER		ENWAY	CENTER I	ORIVE #	430 GI	REENBE	LT,MARYL	AND 20770			
Regis	State strar	31. Date filed (Month, Day, Year) JAN 1 1 2007	32. Registrar's Signat	ped									

1. Decedent's Name (First, Middle, Last) 2. Date of Decedent's Name (First, Middle, Last) 2. Date of Decedent's Name (First, Middle, Last) 2. Date of Decedent's Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3. Social Security Number 2. Social Security Number 2. Social Security Number 2. Date of Decedent 3. Social Security Number 3. Social Security Number 3. Social Security Number 3. Social Security Number 4. Social Security Number	ath Day Year 3. Time of Death
Clarence W. Bishop 4a. Facility Name (If not institution, give street and number) 2531 Point of Rocks Road Funeral Director 5. Social Security Number 227-36-7227 1\overline{\text{M}} \text{M} 2 \subseteq F 74 Yrs. 1 \text{Under 1 Year If Under 24 Hrs. Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Hours Min. April 5 Months Days Months Days Hours Min. April 5 Months Days Months Days Hours Min. April 5 Months Days Months Days Hours Min. April 5 Months Days Months Days Hours Min. April 5 Months Days Months Days Months Days Hours Min. April 5 Months Days M	7, 2007 12:50 P ^M 4c. County of Death Frederick 20,1932 9. Birthplace (State or Foreign County) Virginia
4a. Facility Name (If not institution, give street and number) 2531 Point of Rocks Road Funeral Director 5. Social Security Number 227-36-7227 1\overline{\text{M}} \text{M} 2 \subseteq F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. April 6 Bir 1 Point	4c. County of Death Frederick 20,1932 9. Birthplace (State or Foreign County) Virginia
Funeral Director 5. Social Security Number 227-36-7227 Usual Residence of Decedent 5. Social Security Number 22.7 6. Sex 1 1 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1	9. Birthplace (State or Foreign Country) Virginia
Director 227-36-7227 1 X M 2 F 74 Yrs. Months Days Hours Min. April 5 Usual Residence of Decedent	', 2007 Virginia
	10d Inside City Limits
Maryland Frederick Knoxville 10e. Street and Number 10f. Zip Code	
10f. Zip Code	1 □ Yes 2 No
9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10g. Citizen of What Country?
្ទី ទី 👼 2531 Point of Rocks Road 21758	United States
2531 Point of Rocks Road 21/58 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
The control of the	Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Business/Industry
To the property of the propert	Government
To see that the second	
To the first, Middle, Last) 17. Father's Name (First, Middle, Last) Loyd Bishop 18. Mother's Name (First, Middle, Last) Loyd Bishop 19a. Informant's Name/Relationship (Type. Print) P # # # # # # # # # # # # # # # # # #	,
Composition of the second seco	
Elsie Bishop / Wife 2531 Point of Rocks Road, Ki	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
20a. Method of Disposition Comparison C	Frederick, Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffe:	Funeral Home Brunswick, MD 21716
23a. Part1. Enter the disease, or complications diseased the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line.	
	Interval Between Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	year
Examiner Sequentially list conditions, b	
if any, leading to immediate Due to (or as a consequence or):	
if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
Y TO SEE SEE SEE SEE SEE SEE SEE SEE SEE SE	23d. Date of delivery
Second S	Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did	obacco use contribute to the cause of death?
Spool by Spo	Yes 2 No 3 robably 4 Unknown
The law required to the la	
	prior to completion of cause of death? 2 No 1 Yes 2 No
1 Period 1 P	one)
Hospital: 1 Inpatient 25 FRO Details 1 DoA Other: 4 Nursing Home 5 Resi	
27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Injury at Injury 28b.	how injury occurred
O Pure 1 Pure 2 Accident investigation M 1 Yes 2 No Start and a pure 2 Accident investigation M 1 Yes 2 No Start and Accident investigation M 1 Yes 2 No Start and Accident investigation M 1 Yes	Street and Number or Rural Route Number,
28b. Time of Injury at Work? Natural 2 Accident 3 Suicide 4 Homicide n, State)	
The standing of the standing o	cause(s) and manner as stated. date and place, and due to the cause(s)
29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)
D47169	1-10-2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CMAN-HING HO, M.O. 610 9TH AVE, BRUKWICK, M. State Registrar JAN 1 2 2007 Registrar Registrar	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar JAN 1 2 2007	

		ŀ	For Stata Registrar	State o	of Marylan	-	artment of F tificate of		and M		iene	007	02078
	Obveisi		1. Decedent's Name (First, Middle	e, Last)		-				2. Date of Deal Month	th Day	Year	3. Time of Death
men	Physici /Medio			rginia	Bow	en				Januar	У 8	2007	3:35 P M
2	Examin	er	4a. Facility Name (If not institution	, 3								unty of Death	
			Calvert County 5. Social Security Number	Nursing C	7. Age (In yrs.	last birthdav)	If Under 1 Year	If Under 2		8. Date of Birth		9 Birtho	lace (State or Foreign
Н	Funeral Director		444-01-7662	1 □ M 2 💢 F	89	Yrs.	Months Days	Hours	Min.	June 17	, 191	7 Okla	itry)
	2		Usual Residence of Decedent		40. 07	<u> </u>							
	•hov	5	MD Calv	ort		y, Town or Lo Drince	Frederio	~k				'	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	28e-1	Director	10e. Street and Number	CI C		TTITCC	10f. Zip Code			1	0α. Citizen	of What Coun	itry?
	3a or	ā	85 Hospital Ro	ad			20678	3			_	ted St	•
	death	nera	11. Marital Status		edent Ever in U.	.S. 13. \	Was Decedent of H f Yes, specify Cub	lispanic Orig	gin? (Spe	cify Yes or No-		Race - Americ	
92	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or iteme 23a or 28e-f ehow other traumatic event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Marr	ned 1 ☐ Yes If Yes, Gi	ZX No ive		i ⊓es, specily cub I □ Yes 2X No	Specify:	, Fuerto i	ritoari, etc.,		Black, White, e Black, White, e	
Maryland 21215-0036	hour fure	ed b	3 ☐ Widowed 4 ☒ Divorced	Year or E	Dates:	16a Decec	lent's Usual Occur	nation				of Business/Inc	
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212	giene granthe	ĕ	12	College (1-401 3+)	Ship	ping Cle	rk			elec	trical	supply
ng	be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle,		3					(First, Middle, I	_		
3	2 should be i and Mental I ie marked o aumatic eve	2		nklin	Arnold			Eva			hepar		0.44
<u>a</u>	d2sl than t7 le r traur		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sunny L. Wainwright, Daughter PO Box 601, Owings, MD 20736										
<u>ē</u>	Health tem 27 other tr		20a. Method of Disposition	righte, ba	20b. P	lace of Dispo	sition (Name of			+		ion - City or To	wn, State
Ë	permit. Pages Depertment of Inportant: If Ite eny Injury or of		1 Burial 2 Cremation 4 Donation 5 Other (S		State		natory or other pla tan Crema		01-0	9-07	Alexa	ndria,	VA
Baltimore,	mit. pertr porta y inju		21 Signature of Funeral Service	Licensee		22	. Name and Addre	ss of Facility	у	_			7 7 7 1 1 1 1 1 1 1
m —	89 5 9		Costan	Jul			Rausch F	uneral	L Hon	ne, P.A.	Owir	ngs, MD	20736
3.				Approximate Interval Between Onset and Death									
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	Cardi		Arrh	yth	m_{i}	Ce			Onsor and Boarn
	Examiner		, and a second		(or as a conseq		4'c Ga.	ا مدامه	3000	u dan n	م عاد الم		
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	icate be executed physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S c									
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×	eath certifi attending for use as	/Me	IF FEMALE:	23c. If yes, ou	itcome of pregna	incv					224	Date of delive	
ROX		Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2□Feta nant at time of d	Ideath 3□	Ectopic pregnancy Other <i>(specify)</i>	/			230	Date of delive. Month	Day Year
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	igned be det	by P	Part II. Other significant condition			_	nderlying cause giv	ren in Part I.		23e. Did tol	bacco use	contribute to th	ne cause of death?
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<u>=</u>	n: The		Edema	Legs.						perform 1 ☐ Yes	ned? 2. No	death? 1 ☐ Yes	2□ No
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ö	y Phy er this eral d	<u>1</u>	27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	I 3 DOA	4 Mul		ne 5□ Reside 28d. Describe ho			0
<u></u>	ittending death. ctor: Afte y the fun	atlo	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	19	nth, Day Year)	Injury		k? Yes 2∐1	No				
Division of	i or Atte after de Directo Jin by th	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place	e of Injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory, office		2	28f. Location (SI City or Town		umber or Rura	l Route Number,
	ital o		-										
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the Examiner: On the b	a bast of my kno pasis of examina nner stated.	wiedga, daat tion and/or in	estigation, in my c	ne, date and pinion, deat	d place, a th occurre	and due to the election at the time, d	auso(s) am ate and pla	d intainner as st ice, and due to	atad. the cause(s)
	othe o the omple	Med	29b. Signature and title of certifie		and stateo.		29c. Licens				9d. Date si	gned (Month,	Day, Year)
	- > - 0		· ley	en.C.	200	na.	D	. 50	65	3	1 -	8-2	007
	/m		30. Name and address of person	who completed cau	se of death (Item	n 23a) (Type,	Print) GV			· Su	PAK	17	
	4		5851- I	Deale			1 Road	1	Dec	ale 1	n.D.	207	51
	Sta Registi		31. Date filed (Month, Day, Year)	1 0 2007	Registrads Signa	iture	1. 0.						
DHI	MH 17 Rev 1/2		JAN	TO Choi	JUL SILE	1 15	PROBAGE						

DHMH 17 Rev 1/2001

07-00533 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Covington State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Death Month Day January 19, 2007 Medical Examiner 1648 hrs Robert Charles Covington 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 235 Oakwood Road Edgewater Anne Arundel If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Foreign Director Days Hours Country) Maryland 1 X M 2 Yrs 52 05/11/1954 219-64-5785 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County Oc. City. Town or Location Yes 2 X No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene nant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ry other transmatic event, the Medical Examiner must be notified at near Maryland Anne Arundel Edgewater Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 235 Oakwood Road 21037 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 1 Yes 2 No specify: Specify: White Widowed Divorced If Yes, Give Year 4 ۵ or Dates 16a Decedent's Usual Occupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Heating and A/C Mechanic 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Clyde Covington Camilla Beatrice Few ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) timore, MD Kathy Ellenes/Sister 1604 Chesapeake Drive, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) Department of 01/22/2007 Edgewater, Maryland Kalas Crematory Donation 5 Other Specify. 0 22. Name and Address of Facility George P. Kalas Funeral Home neral Service Licenses 2973 Solomons Island Rd., Edgewater, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure List only one cause on each line /Medical Death a Hypertensive cardiovascular disease Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) andtran The law requires that the death certificate be execu Physician/Medical X UNPENDED **AMENDED** attending physician or use as the burial -#23a27,perME Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the Live birth Day 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown by the Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I ð Yes 2 No 3 Probably 4 V Unknown Completed s been si 24a, Was an Were autopsy findings available autopsy prior to completion of cause of has performed? death? After this certificate liuneral director, page ✓ Yes ✔ Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other 4 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Scene 1 V Yes ۵ No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Pending death. To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

\$

State Registrar

29b. Signature and title of certifie

mol

Tasha Greenberg MD.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 20, 2007

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2 6 2007

			1 - For State Registrer	State of Ma	aryland	•	artment rtificate			and M		gien Reg. N	2007	02080
ý	Physici /Medio Examir	al	Decedent's Name (First, Middle, Samuel Cant Aa. Facility Name (If not institution,	у			4b. City,	Γown, or	Location o		2. Date of De Month	D	Year 7 2007	
	Funeral Director	CI	Clinton Nurs: 5. Social Security Number 251-22-0590			ter ast birthday) Yrs.	If Under Months	1 Year Days	Clint If Under	24 Hrs. Min.	8. Date of Bin (Month, Da	y, Yea	9. Bir	c George's thplace (State or Foreign ountry) 1th Carolina
	D	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	e George's		r, Town or Lo	cation		Clint		/CL 9 21	• · · ·	724 300	10d. Inside City Limits V Yes 2 □ No
	J within 72 hours after deeth with the Maryland jiene. I then Insture!; or Iteme 23e or 28e-f show I'le Me Jical Exercise from Le Incilled at	Funeral Directo	10e, Street and Number 9211 Stuart 11. Marital Status 1 □ Never Married 2 Marrie	12. Was Decedent Armed Forces?		S. 13.	10f. Zip Was Deced f Yes, spec		2073 ispanic Origin, Mexican		cify Yes or No Rican, etc.)		United 14. Race - Am- Black, Whi	States erican Indian,
9500-61212	"natural", or	þ	3 Widowed 4 Divorced 15. Decedent's (Specify only highest	If Yes, Give Year or Dates:		16a. Dece	1 ☐ Yes 2 dent's Usua kind of won DO NOT us	l Occup	ation	t of workir	ng	16b.	Specify: Kind of Business	Black
	Hyg Hyg the oth	Be Completed	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, La		5+)	ire.			Map Se		e (First, Middle,	Maide	Govern en Sumame)	ment
ore, Maryland ss 1 and 2 should be file of Health and Mental Hy litem 27 is marked oth r other traumatic event			Unknown 19a. Informant's Name/Relationshi Moses C. Mobl	p (Type, Print)		19b. Mailir					Mary Route Number IE Was	er, City	or Town, State,	
altimore,	permit. Pages 1 a Depertment of He- Important: If Itam any Injury or othe		20a. Method of Disposition 1 Deprinal 2 Cremation 4 Donation 5 Other (Special Service Li	B □ Removal from State	CE		sition (Name natory or of	e of her place	tery	1/13/	2007	20c.	Location - City or Brentwood	Town, State
g	Depermination of the service of the		23a. Part1. Enter the disease, or c shock or heart failure. List or	Stewar X complications that caused	the death			01 1	Benni	ng Ro	l., NE	Wa	ral Home	
	Physician /Medical Examiner		Immediate cause (Final disease or condition resulting in death)	a. Card Due to (or as	io-re a consequ	espira Jence of): sive c				4400				Onset and Death
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ecords, P	requires thet the neen signed by th hould be detache	þ	Part II. Other significant condition	s contributing to death be	ut not resu	ulting in the u	nderlying ca	use grve	en in Part I.				use contribute to	o the cause of death?
Vital Rec	The lay ate has page 2	e Completed	25. Was case referred to medical						OC Disease	of Dooth	1 ☐ Yes	sy rmed? 2\(\) N	death?	utopsy findings available completion of cause of
5	Phy this ald	To B	examiner? 1 Yes 2\(\) No 27. Manner of Death 1\(\) Natural 5 Pending	28a. Date of Inju (Month, Da)		ER/Outpatien 28b. Time of Injury		Bc. Injun Work	er: 4 🖾 Nu / at k?	rsing Hom	(Check only one 5 Resident Res	dence	6 ☐Other (Spe	ocify)
DIVISION	in the se	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injude	c. (Specify	")	eet, factory,	office	Yes 2 □ f	2	City or Tov	vn, Sta	ite)	ural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 2 Medical E	Physician: To the best of caminer: On the basis of and manner sta	examinat	wtedge, death ion and/or in	vestigation,	in <i>m</i> y op	ne, date and pinion, deat e number	d ptace, a th occurre	d at the time,	date ar	s) and manner and place, and durant signed (Mon	e to the cause(s)
0	(5)		30. Name and address of person w				-		60	99	9		1/11	107
	Sta	te	Aruma Paspul 31. Date filed (Month, Day Year) JAN 1 2 2007	a, M.D. 106			• , NW	#41	.5 Wa	shin	gton, I	OC 2	20010	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year :34PM **Physician** Juanita C. Crider lanuar 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. 578-30-5116 78 Aug 9, 1928 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 √Yes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6150 Princess Garden Parkway 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No timore, Maryland 21215-0036 Specify: Specify: ģ 3X Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Secretary Government If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental John Murray Mary Schemerhorn ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Davis (Daughter) 2290 Gambrell Lane, Colorado Springs, CO 80919 Department of Health Important: If Item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □Cremation 4 □Donation 5 □ Other (5 3 Removal from State Gate of Heaven Cem. 1/15/2007 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 ht1. Enter the isease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart all in . List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gastrointestinal 10 days **Physician** /Medical Due to (or as a consequence of): 2WKS Examiner Se PSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner mouth that the death certificate be executed and burial-trai WKS Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the a 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, OESTILL TIVE Pulmonan 1. Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an page 2 s certificate has autopsy 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058213

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31. Date filed (Month, Day Yea

tur hay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAKIHAD JAMALIMD 7305 F 7305 Hanover PK WY Green belt MD 20770. 32. Registrar's Signaty

Registrar

			1 - For State Registrar	State of Mary		artment of			ene	00000
	*	Ž.	Registrar 1. Decedent's Name (First, Middle, I	l astl		Timoato o		2. Date of Death	2001	3. Time of Death-
3	Physicia	an	Catherine Alic					Month	Day Year 7 9, 2007	10:10 a M
2.8	/Medic	al				4h City Town	, or Location of Deat		4c. County of De	
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	Funeral		577-18-5874	1□ M 2(XF 87	Yrs.	Months Day	s Hours Min.	(Month, Day,)	(ear) , 1919 Vi	rginia
- 52	Director		Usual Residence of Decedent	07				pept. I.,		
	land ow		10a. State 10b. County	100	c. City, Town or L	ocation				10d. tnside City Limits
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	1 the	Director	10e. Street and Number			10f. Zip Cod		100	g. Citizen of What (Country?
	3a o	0	105 Rod Circle)			21769		USA	
	72 hours after death with the Maryland Inatural; or Items 23e or 28e-f ehow Vicel Executor must be nutified at	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13	. Was Decedent	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No-	14. Race · An Black, Wh	nerican Indian,
က	or Ite		1 Never Married 2 Marrie	d 1 ☐ Yes 2 🛣 No		1 ☐ Yes 21 €		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SpecifWhi	
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Maryland	2 should be and Menta Is marked sumatic ev		19a. Informant's Name/Relationshi			-		Rural Route Number, , Hyattsv:		
	5 ₹ Z ₹		Joanne M. Mood/						Oc. Location - City	
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二二	permit. Departi Importi any inj		21. Signature of Funeral Service Li	censee		Francis	gess of all in	sFuneral	Home Inc	
<u>m</u>	89 2 2 9	10	J. Ken Stile							ing, MD 20901
			23a. Part . Enter the disease, or of shock, or heart failure. List of	nly one cause on each line.	A				st,	Approximate Interval Between Onset and Death
М	Physician		Immediate Cause (Final disease or condition	POST OF	BSTRUL	TIVE	KNEUN	ONIA.		Chief and Boain
4	/Medical		resulting in death)	Due to (or as a co	onsequence of):					
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	cute	Examiner	Cause (Disease or injury that initiated events	С.	MYTU					
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89	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE:							
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P.0	at the	Phy	9 Unknown		at annulting in the	undertung agua	annos is Bart I	23e Did tob	acco use contribut	e to the cause of death?
	The law requires that the death tte has been signed by the atter age 2 should be detached for u	b	Part II. Other significant condition	is contributing to death but in	iot resulting in the	didensying cause	giveir arr unc i.	1□ Ye		Probably 4 Unknown
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<u> </u>	The law	100						perform 1 Yes 2	1 0 Y	es 200 No
Vital	ding Physician: The h. After this certificete funeral director, pag	Be (25. Was case referred to medical examiner?					eath (Check only one	∍ /	
of V	hysic his co	ို	1 ☐ Yes 2 ♠ No	Hospital: 1 I hpatient	2 ER/Outpat			Home 5 ☐ Reside		Specify)
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	•		30. Name and address of person was trible TDN	who completed cause of deat	th (Item 23a) (Tyr	Print)	MAPAR	HAMIM N. MD.	1005-	2 ,
	man and an article		31. Date filed (Month, Day, Year)	32 Agnistraris	s Signature	1				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 9 2007 2007 **Physician** 10:42 P M CATLIN **JAMES** EUGENE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 293-14-5791 Director 84 Nov. 4, 1922 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ns 23a (7407 Willow Road Suite 252 21702 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ⊠Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify. Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Intelligence Analyst U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be William Hobart Catlin 2 Gertrude Patton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Y. Catlin / Wife 7407 Willow Road, #252 Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State January Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2007 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sonature of Function Service Licenses 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** umone /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ No. 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Dena rome Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No NZInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director; A death. 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and thie of certifier 30. Name and address of person (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year BEVERUE MAD 02 0625 2007 /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NINSULA Kegional MEDICAL Wicomico SALISBURY ENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KF Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 □ No Director DIVALYE Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21814 JSA LOAD 20615 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify WHITE ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CAP TELEPHONE LEPHONE OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be SOSEPH FAHNK BELANGE SPECHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 tem eny Injury or other traum SHARON CORRY DAUGHTER 20675 COVERD BIVALVE, MID 21814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 DCremation 3 ☐ Removal from State SAUSBURY CREMIATORY SALISBURY, MID 4 ☐ Donation 5 ☐ Other (Specify) 1-3-07 22. Name and Address of Facility
MESSICK FUNERAL HOWE PO BOXE!
BIVALVE, MD BISHY 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 20075 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 724 Due to (or as a consequence of) Examiner the attending physicien and thed for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy signed by the atte Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>გ</u> cete hes been si, page 2 should t 3 Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2□No of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending F Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

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			1- State of Maryland / Department of Health State of Maryland / Department of Health Registrar 29d per dr., 886 / 05/10/07	h and Me dhb	ental Hygi	iene _{g. N} 2 0 0 7	02085						
Н	Physici	an	1. Decedent's Name (First, Middle, Last) Freddie Irvin Clingman	2	2. Date of Death Month	Day Yea							
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Crescent Nursing Home 4b. City, Town, or Location Riverda.		01 (09 2007 4c. County of De Prince							
χ.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	nder 24 Hrs. g	8. Date of Birth (Month, Day, 10/18,	Year)	irthplace (State or Foreign Country) nston Salem N.C.						
	anylan show	ž	10a. State 10b. County 10c. City, Town or Location Md P.G. Mitchellville				10d. Inside City Limits 11 Yes 2 □ No						
	with the M s or 28e-f	Director	Md P.G. Mitchellville 10e. Street and Number 3300 Saville Lane 20721		10	0g. Citizen of What							
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "neturel", or items 23c or 28e-f show event, I're Medical Eventral Terms 12c maillish at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give 1 Yes, Give 1 Yes 2 No Spec		ify Yes or No- ican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc. Black						
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Maryland		To Be	Wallace Clingman D	orothy	y Will								
Mai	d 2 s		19a. Informant's Name/Relationship (<i>Type, Print</i>) Frederick I. Clingman Son 19b. Mailing Address (Street and Nur 4409 Rev Davi Upper Marlbor	s Dr.	Route Number, 20777 2	City or Town, State	, Zip Code)						
Baltimore,	一十五二		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Wash. National	Da	ite 2	20c. Location - City of Suitlar	or Town, State						
Balti	permit. Pages Department of the Importent: If ite any injury or of once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snead Mortuary Service, F.A. 1409 Fairlakes Place Ste B Mitchellville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Md										
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Matastatic Cardina MA LVNG											
	/Medical Examiner		Due to (or as a consequence of):	<u> </u>			years.						
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events Due to (or as a consequence of): Cuse (Disease or injury that initiated events										
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.O. Box 6	death certifi e attending I id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of o	lelivery Day Year						
rds, P	quires that n signed b uid be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.		_	to the cause of death? Probably 4 □Unknown						
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/ita	i cien : Th certificate rector, pag	Bec	examiner?	Place of Death ((Check only one								
of	ng Phye fter this ineral di	tion; To	1 Yes 2 No	28		nce 6 □Other (Sp w injury occurred	pecify)						
Division	et or Attending s after death. It Director: After d in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,							
	To the Hospitel of within 24 hours affection 24 hours affect the Funerel Discompletely filled in	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, or and manner stated.	e and place, an death occurred	nd due to the ca d at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)						
	To the To the comp	Ň	29b. Signature and title of certifier Paullin Deliver Do 135	52	9	anuary 9	mar EUDI						
	سند		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ed Hy	allsin	HeMD.	20181						
	Sta Registi		JAN 1 0 2007 JAN 1 0 2007 JAN 1 0 2007										

			1 - For State Registrar	State of Mary		artment of H rtificate of			ene	07	02086
	Dharaisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death		V = 1	3. Time of Death
4	Physici /Medi		Donald Dawso	n				Month January	Day 2	Year 007	3:00 P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	-	4c. County		
			19556 Crystal R				Germantov	m	M	ontgo	nery
п	Funeral		Social Security Number 6. Security Number	7. Age (In	yrs. last birthday)	Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Countr	ace (State or Foreign
	Director		579-64-2169 Usual Residence of Decedent		58 Yrs.			May 10,			h., DC
	fand m		10a. State 10b. County	100	c. City, Town or Lo	ocation				100	d. Inside City Limits
	Many it sh	ţ	Maryland Montgo	morri		Co					1 Yes 2 □ No
	7 28a	Director	10e. Street and Number	шегу		10f. Zip Code	rmantown	10	g. Citizen of V	What Countr	v?
	13a o	<u>-</u>	19556 Crystal	Rock Drive.	#22		20874			ed Sta	
	within 72 hours after death with the Maryland ene. then "naturet", or iteme 23a or 28a-f show ha Madigal Examinar must be ricitiised at	by Funeral	11. Marital Status	12. Was Decedent Ever		Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - America	
9	or its	교	1 XNever Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 MNo If Yes, Give				Rican, etc.)		k, White, et	
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12	within ne.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)				
22	Hygie Hygie Ither I		12th 17. Father's Name (First, Middle, Last)			Counse				ivate	
ano	ntal h	Be	Thomas Stewart	Davidon			18. Mother's Nam	e (First, Middle, Ma		7e)	
2	d Me d Me mark	မ	19a. Informant's Name/Relationship (7		401 11 31			Mary Car	-		
Maryland	d2s than trau	1		,			and Number or Rur			State, Zip C	ode)
ā,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23s or 28s-f show with injury or other traumatic event, the Medical Examinat must be notified at annote.		Donita J. Dawso 20a. Method of Disposition		Db. Place of Dispo	16 - 35th	Р1., Нуа		MD :	20782	m State
Baltimore,	ages ont of t: if if		1 Burial 2 MCremation 3 D	Removal from State	cemetery, crei	natory or other place	(e)			•	
₽	artme ortan Injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licent		Lee's	Cremato	ry 1/12				MD
ä	Depa Depa Impo eny i		D. TS	20.5	24	2. Name and Addre	. 5	tewart Fu			
			23a. Part Enter the disease, or comp	lications that caused the	death. Do not ent	er the mode of durin	Benning R	d., NE V	Wash.,		0019 Approximate
	Dharaisian		shock or heart failure. List only of Immediate Cause (Final	ne cause on each line.		or the mode or dyin	g, such as cardiac	or respiratory arres	ı,	10	nterval Between Onset and Death
N. Carlot	Physician /Medical		disease or condition resulting in death)	a. Severe Due to (or as a con	Hypogly	cemia					2 weeks
	Examiner										
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0.	the a	sici	1 Yes 2 No	4☐Pregnant at time 9☐ Unknown		Other (specify)			Mor	nth D	ay Year
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Division of Vital Records,	signe Signe d be	by	Tarris only significant conditions co	TRIBUTELLY TO GOZITI DUT FIOT	resulting in the u	nderrying cause grvi	en in Part I.				cause of death?
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ě	e law has je 2 s	d E						24a. Was an autopsy	1 0	Vere autops rior to comp	y findings available pletion of cause of
<u>=</u>				<u> </u>				performe 1 ☐ Yes 2 ☐	<u>id</u> ? d	eath?	□ No
*	ysician: is certific director,	Be	25. Was case referred to medical examiner?	lospital:		100		Check only one			
ō	Attending Physician: r death. ector: After this certifice by the funeral director, i	5	1 Yes 2 No 27. Manner of Death	1 L Inpatient	2 ER/Outpatien		4 Nursing no	me 5 Residence			
0	ding Phy h. After thi funeral	ertification;	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury	Work		28d. Describe how	injury occurre	ed	
18	or Attendate death Director: in by the	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	At home farm str		Yes 2 □No	28l. Location (Stree	at and Mumbe		7
á	al or A after Direct	ert	4 Homicide determined	building, etc. (Sp	ecify)	ser, raciory, onice		City or Town,	State)	er or Hurai H	loute Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	ac	29a. Certifier 1 位 Certifying Phy	sician: To the best of my	knowledge, death	occurred at the tim	ne, date and place	and due to the caus	se(s) and ma	nner as etate	ed
	he Hk in 24 he Fu oletel)	edical	(Check only 2 Medical Exami	ner: On the basis of exam and manner stated.	nination and/or inv	estigation, in my or	pinion, death occurr	ed at the time, date	and place, a	nd due to th	e cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1		29c. License			. Date signed		
			Dunken /	WILLIAM	M.D.	1000	40201	JA	NUAR	y 9th	2007
0	121		30. Name and address of person who co								
1	()		Farzad Ass	ar, M.D	One Exec	cutive Pa	rk Court,	Germanto	own, M	208	74
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnat						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DEHBOZORGI 9, TRAN January 12:20FM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesou | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June | 27, 1923 Suburban Hospital Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Director 212-51-1435 83 Iran Usual Residence of Decedent 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No Chevy Chase Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iran 20815 6302 Wisconsin Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3√ Widowed 4 Divorced Specify: White þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe ALIAKBAR MOHTARAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alireza Farshneshani – Son 6302 Wisconsin Ave., Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mashad Imam Reza's Mashad, Iran 4 □ Donation 5 □ Other (Specify) Shrine : 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudoun Funeral Chapel Melmarla 158 Catoctin Circle, SE, Leesburg, VA 20175 23a. Part1. Enter the same, or complications to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart the re. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial /Medical Due to (or as a donsequence of): Examiner Triple vessel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş Plerre Hyponatrenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed. 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident I or Attend after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

כ

Registrar

State 31. Date filed (Month, Day, Year)

H. ABL

Akhondi, MD, 7503 Surratts Road, Clinton, Maryland

AN 1 2 2007

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Spark

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			State of Maryland / Dep	partment of Hea	Ith and M			00000
		L		ertificate of De	ath	Reg	J. N6 UU /	UZUOO
	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
	/Medi		Margaret Elizabeth Duval	1		January		8:30 A. ^M
}	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca	ation of Death		4c. County of Deat	h
			25804 Bowman Acres Lane	Damascus			Montgom	ery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birti	nplace (State or Foreign untry)
	Director		218-20-2086 1 M 250 80 Yrs. Usual Residence of Decedent			Aug. 3,		yland
	and		10a. State 10b. County 10c. City, Town or I	Location				10d. tnside City Limits
	f ehc	ō	Manual and Manual and D					1 ☐ Yes 2X No
	the 288	-ec	Maryland Montgomery Damasco	10f. Zip Code		100	. Citizen of What Co	untov?
	death with the Maryland ime 23a or 28a-f ehow if must be notified at	٥	25804 Bowman Acres Lane	20872				unity :
	ne 2	era			nic Origin? (Spe	city Yes or No-	U.S.A.	ncan Indian
' 0	r iter	듄	Armed Forces? 1 ☐ Never Married 2 ☐ X Married 1 ☐ Yes 2 X No	. Was Decedent of Hispan If Yes, specify Cuban, Me	exican, Puerto I	Rican, etc.)	Black, White	
930	urs a	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Sp	pecify:		Specify: Wh	ite
Š	2 ho	Completed by Funeral Director	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during		16	ib. Kind of Business/	Industry
2	hin 7	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)	g most of workli	ng		
21	gian.	5		nemaker			Own Home	
g	al Hy	Be (17. Father's Name (First, Middle, Last)	18.	Mother's Name	(First, Middle, Ma	uiden Sumame)	
/la	Ment Ment Mrkec	2	Harold Edward Burdette		Eva Ma	ude Bar	ber	
Maryland 21215-0036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "neturel", or iteme 23s or 28s-1 show any njury or other treumatic event, the Mudical Examinar ment be notified at ADEC.		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and N	Number or Rura	l Route Number, (City or Town, State, 2	ip Code)
	and eelth n 27			04 Bowman Ac	res Lan	e, Damas	cus, Mary	land 20872
ore	of H of H or oth		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State	oosition (Name of ematory or other place)	D	ate 20	c. Location - City or	Town, State
Baltimore,	Pag ment ant: ury c			s Cemetery	1/12	/07	Damascus,	Maryland
<u>=</u>	Depention of the popular of the popu	ŀ	21. Signature of Funeral Service Licensee	22. Name and Address of	Facility	. D A T	1 11	
_	20 E 29			Molesworth-W 26401 Ridge	Road, D	amascus.	_Marvland	ne _2087 <i>2</i>
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ı	Physician		Immediate Cause (Final disease or condition Congestive Hear					Onset and Death 10 YRS
	/Medical		resulting in death) Due to (or as a consequence of):					10 1110
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	D #	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypertensive Cause)					
	ate be executed hysicien and he burial-transit	am	that initiated events	rdiomyopathy				10 YRS
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x 68	thet the death certiticat ed by the ettending phy detached for use as th	Physician/Medi	IF FEMALE:					
Вох	attend stend for us	ian		Ectopic pregnancy			23d. Date of deli	very Day Year
o	the de	ysic	1 ☐ Yes 2 X No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)				,
P.0.	thet the ad by detac	P	Part II. Other significant conditions contributing to death but not resulting in the	underwing cause given in	Part I	23e Did tobar	cco use contribute to	the cause of death?
ds,	w requires the been signed I should be det	d by	Chronic anemia secondary to colonic v					bably 4 Unknown
ö	requ been shoul	Completed						
Vital Records,	has ye 2	m m	and chronic disease, Rheumatoid Arth	ritis, Depre	ssion,	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
_ 	n: The licete		anxiety, Hypercholesterolemia, Parkin	nsons		performe 1 ☐ Yes 2X	No 1 ☐ Yes	2 No
₹	certil recto	Be	25. Was case referred to medical examiner?			(Check only one)		
ō	Physical distribution	7	1			19 5 X Residence 8d. Describe how	e 6 Other (Spec	ify)
o	ding h. Afte tune	tion	tX Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes		.au. Describe now	injury occurred	
2	deat ctor: y the	Certification;	3 Suicide 6 Could not be 28e Place of Iriury - At home farm s			Rf Location (Street	et and Number or Ru	ral Pauta Number
Division of	or A elter Direct	erti	4 Homicide determined building, etc. (Specify)	reet, lactory, onles		City or Town, S	State)	ar noute Number,
-	To the Hospital or Attending Physician: The law requires thet the death certitical within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the ettending phy completely tilled in by the tuneral director, page 2 should be detached for use as the	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time da	ate and place a	nd due to the caus	se(s) and manner as	stated
	• Ho • Fu • Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion	n, death occurre	d at the time, date	and place, and due	to the cause(s)
	To th within Fo th	Me	29b. Signature and title of certifier	29c. License num	nber	29d	. Date signed (Month	, Day, Year)
)	. , , ,		I Comma & Hy many M	D003468	82		Ianuara 0	2007
١	0		30. Name and address of person who completed cause of death (fight 23a) (Type		02		January 9,	2007
	10		Joanne L. Kinney M.D. 9701 New Chu		Damasc	us. Marv	land 20872	,
	Sta	te	31. Date filed (Month, Day, Year) 32. Ministrar's Signature			_ , <u>y</u> .		
	Registr	ar	IAN 1 2 2007 Beaut & A	marin				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:45 MP **Physician** January 8, 2007 Pearl Kathleen Dykes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27729 Log Cabin Road Wicomico Salisbury If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Pay Year) 2/2/1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗑 F Maryland 93 Director 216-80-2947 Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at Maryland Wicomico Salisbury 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27729 Log Cabin Road 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy important: If Item 27 is marked othen yillury or other treumetic event William Theodore Parker Naomi Gnagey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Henry Dykes/husband 27729 Log Cabin Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of competery, crematory or other place Springhill Memory Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 1/16/07 Hebron, MD 4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licensee PHOTIOWAY PULTERAL Home Professional Association once un Ha 501 Snow Hill Rd., Salisbury, MD 21804 25a. Pert1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 Unknown been signed by Part II. Other significent conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 1 No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were aulopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No hes autopsy performed' this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Des 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ို ŧ 2 ER/Outpatient 3□ DOA 27. Manna of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funerel I To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 The bical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and tile of 29d. Date signed (Month, Day, Year) 450497 10/07 Chris Sny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salishy E. Carroll 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 1 1 2007

State of Maryland / Department of Health and Mental Hygiene 02090 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Isabel Devereux Elkins January 7, 2007 2:35 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chevy Chase Montgomery 8305 Kerry Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖺 F 88 Yrs 09/29/1918 Pennsylvania Director 201-10-7229 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at 1X Yes 2 □ No Chevy Chase Montgomery Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20815 8305 Kerry Road deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 ie marked other the eny injury or other treumatic event, this page. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Ashton Devereux Elisabeth Dorenda Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2821C Seclusion Ct. Raleigh, NC 27612 Steven B. Elkins IV / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet. Jan. 13, 07 Silver Spring, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure Weeks /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4XXUnknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the autopsy performed? 2 🗆 No 1 Yes 1 TYes 2 (3t No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA safter deam, ral Director; After this read of the funeral directors and the funeral directors an 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number Willen MD40216 Jan. 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis A. Cullen MD 7625 Wisconsin Ave. # 101 Bethesda, Md 20814 31. Date filed (Month, Day, Year) 32. bgistrar's Signature State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1/5/2007 9:22 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Apt #221 7511 Buchanan Street Hyattsville Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Director 8/16/1925 430-32-3509 ARKANSAS Usual Residence of Decedent with the Manyland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar the modified at MD PRINCE GEORGE'S HYATTSVILLE 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7511 Buchanan St. Apt. #221 20784 U.S.A. filed within 72 hours after death Hygiene. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Foreman Construction 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any lipiry or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) John Fields Pearly Reeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7511 Buchanan St. Apt. #221 Hyattsville, MD 20784 Rosalee Fields/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/07 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. Brentwood, MD 21. Signature of Funeral Service-22. Name and Address of Facility Ft. Lincoln F. H. 3401 Bladensburg RD., Brentwood, MD 20722 23a. Part1. Enter the mease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Prostate Carcinoma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2\(\Delta\) No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) lun D 0058290 1/10/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Muppttaph, MD 5711 Sarvis Road Suite 200 Riverdale, MD 20737 31. Date filed (Month, Day, Year JAN 1 1 2007 32. Registrar's Signature State Registrar

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)	Physician /Medical Examiner
	Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, Registr

	1 - State Registrar			Ce	Certificate of Death Reg. No. 2007							2072	-		
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П	19a. Informant's Name/Relationship								al Route Numb				ip Code)		
	Joseph Fox/Grands	on					g Roa		Churmon						
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 [☐Removal from State	1 001	ice of Disp metery, cri	oosition (Nam ematory or ot	ie of her plac	e)	1	Date	20c.	Location	- City or 1	Fown, Sta	te	
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	21. Signature of Funeral Service Lie								uffer						
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	23a. Pa 11.F the disease, or co shick or heart failure. List only immediate Cause (Final	y one cause on each	line.	Do not ei	nier ine mode	e or ayını	g, such as	cardiac	or respiratory a	ırrest,			Approx Interva Onset	al Between and Death	
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Medical Examiner	resulting in death) Last	Due to (or a	s a conseque	ence of):			-								
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	23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcom 1 ☐ Live birth			□Ectopic pre	egnancy				- 3		ate of deli	very Day	Year	
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Be Completed by Physician/	Part II. Other significant conditions	contributing to death	but not result	tina in the	underlying ca	use dive	en in Part	I.	23e. Did	tobacco	use co	ntribute to	the cause	e of death?	
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atio	Natural 5 Pending Accident investigation	(Month, E	ray rear)	Injury	М		Yes 2 □	No							
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Medical Certification;	(Check only 2 Medical Exa	hysician: To the bes aminer: On the basis	of examinati	/ledge, dea	ath occurred a investigation,	at the tin in my o	ne, date a pinion, de	nd place, ath occur	and due to the	cause , date a	(s) and r	manner as e, and due	stated. to the ca	use(s)	
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	and w		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or I	_ocation				10d. Inside City Limits
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)	288	Director	10e. Street and Number			10f. Zip Co	de	10	og. Citizen of What Co	untry?
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or itama 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutified at ance.			daughter				ambridge,		ip Code)
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Ä	Depariment Department Important Income.		I the les long	ex				ambridge,		
			23a. Part1 Enter the disease, or compli	cations that caused th	ne death. Do not e	nter the mode o	f dying, such as cardi	ac or respiratory arre	est,	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	ie cause on each line.		0.1.	1 +5			Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	you in	tarclion			10 hours
	Examiner		O CONTRACTOR OF THE PROPERTY O	athero	Storotiz	cordia	vascular	diserce		3 year
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):			J 7 7 003 (7 -00 7
	cate be executed oblysicien and the burial-trensit	Examiner	that initiated events	·						
ő,	e exe	EX	resulting in death) Last	Due to (or as a	consequence of):					
8760,	ate b	dical		l		·				
9	oertific anding p	/Me	IF FEMALE:	20 If you guidanne of					1	
Вох	eath certifi ettending (for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	Fetal death 3	□Ectopic pregr			23d. Date of del Month	ivery Day Year
<u>Р</u> О	that the death ed by the ette detached for	yslo	1 ☐ Yes 2 ဩNo 9 ☐ Unknown	4☐Pregnant at tir 9☐ Unknown	ne or death 5	Other (special	(y)			,
	The law requires that the death certifi ste hes been signed by the ettending t page 2 should be detached for use as	-P	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying caus	se given in Part !.	23e. Did tob	acco use contribute to	the cause of death?
ds	uires sign ld be	d by	Type II Digheter	: mellitus.	hoperte	nsizh	_	1 □ Ye	s 2 No 3 Pr	obably 4 Munknown
00	w require been si should I	lete			//			24a. Was ar	24h Wara au	stancy findings available
Re	he lav	Completed				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		autops	y prior to	itopsy findings available completion of cause of
ā	in: T ificet	ပိ	25. Was case referred to medical							2□ No
₹	Physician: The la r this certificete hes ral director, page 2	100	examiner?	lospital:	2 ER/Outpati	ent 3 DOA	Othor	eath (Check only one		
ō	Phy ar this eral o	n; To	27. Manner of Death	28a. Date of Injury (Month, Day			Injury at Work?	28d. Describe ho	nce 6 Other (Spe w injury occurred	ciry)
lo	nding Ith.	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	rear) injury	М	Work? 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	Atte acto by th	1	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	y - At home, farm,	street, factory, or	ffice		reet and Number or Ru	ural Route Number,
Ö	s afte	Certification;		building, etc.	(Specify)			City or Town	, State)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Diractor: Atter th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician. To the best of ner: On the basis of a	my knowladge, der	att occurred at t	ha time date and pla	ca, and dua to the ca	use(s) and marrier at ite and place, and due	ttaled.
	the Hin 24 the Find 24 the Find 24 the Find 24 the Find 24 the Find 24 the Find 34 the Fin	Medi	one,	and manner state	id.					
	S T W T	Σ	29b. Signature and title of certifier	1 01/		29c. L	icense number		d. Date signed (Mont	ח, Uay, Year)
,				Llle	M.D.		22080	4	1-1-0	1
			30. Name and address of person who co			e, Print)	6 - 1	idge, ND	211 13	
	- 0	l ste	31. Date filed (Month, Day Year)	32. Registrar	Signature	, stree.	1 Cambr	ioge, MD	01615	
	Sta Regist		3AN 1 1	2007 40	M. A.	Acoust				

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

iteme 23a

ō

Direct

with the Maryland

1. Decedent's Name (First, Middle, Last)

THOMAS

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

5. Social Security Number

Usual Residence of Decedent

225-62-8922

10e. Street and Number

10a, State

MD

4a. Facility Name (If not institution, give street and number)

DOCTOR'S HOSPITAL

10b. County

6408 CABIN BRANCH COURT

15. Decedent's Education

(Specify only highest grade completed)

Ε.

12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ NoARMY If Yes, Give Year or Dates:

College (1-4or 5+)

1 □ M 2 □ F

PRINCE GEORGE'S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

JR.

10f. Zip Code

20743

1 ☐ Yes 2X No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

4b. City, Town, or Location of Death

| Months | Days | Hours | Min. | B. Date of Birth (Month, Day, Year) | Oct. 26 19

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

LANHAM

GARDNER

Yrs.

CAPITOL HEIGHTS

10c. City, Town or Location

7. Age (In yrs. last birthday)

2. Date of Death

Tanuaru

Month

3. Time of Death

9. Birthplace (State or Foreign

BLACK

10d. fnside City Limits

1 Yes 2 No

10:45AM

Year

PRINCE GEORGE'S

VIRGINIA

14. Race - American Indian, Black, White, etc.

2007

4c. County of Death

10g. Citizen of What Country?

U.S.A.

Specify:

16b. Kind of Business/Industry

1945

		1 - For State Registrar	State of Marylan	d / Depa		f Health and I	Mental Hyg	•	02095			
Physici /Medic		Decedent's Name (First, Middle, Last) ALGIE	D.	GRAY			2. Date of Deat Month JANUARY	Day 2007	3. Time of Death 5:00P			
Examir		4a. Facility Name (If not institution, give s 201 EASTMILL AVEN	IUE	January Company		n, or Location of Death SEAT PLEAS. par If Under 24 Hrs.	ANT		PRINCE GEORGE'S			
Funeral Director		5. Social Security Number 6. Sex 577-46-5924 1団	7. Age (In yrs.	Yrs.	If Under 1 Ye Months Da		8. Date of Birth (Month, Day, AUG. 5	Year) 9. Bir 1935 SOU	thplace (State or Foreign nurtry) TH CAROLINA			
e Maryland la-f ehow	ctor	10a. State 10b. County MD PRINCE GI		y, Town or Lo SEAT P	cation LEASANT				10d, Inside City Limit: 1 ☑ Yes 2 ☐ No			
th with th 23a or 28	Funeral Director	10e. Street and Number 201 EASTMILL AVENU	JE		10f. Zip Cod		1	Og. Citizen of What Co U.S.A.	ountry?			
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or iteme 23a or 28a-f show event, the Marchal Exember must be mailfied a	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 MDivorced	2. Was Decedent Ever in U Armed Forces? 1∑Yes 2 □ No Na If Yes, Give Year or Dates:	.s. 13.1	Was Decedent f Yes, specify (1 ☐ Yes 2🎇	of Hispanic Origin? (Si Cuban, Mexican, Puerto No Specify:	pecify Yes or No- pecify Yes or No- pecify Yes	No- 14. Race - American Indian, Black, White, etc. Specify: BLACK				
within 72 ho ene, than "natur the Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	ation completed) College (1-4or 5+)	(Give	DO NOT use re	ne during most of wor. tired)	king	16b. Kind of Business/Industry GOVERNMENT				
should be filed volumerical Hygier marked other imatic event, it	a	17. Father's Name (First, Middle, Last) PERNELL MCDOWELL		ENGIN	EEK IEC	HNICIAN 18. Mother's Nam NELLIE	18. Mother's Name (First, Middle, Maiden Surname)					
permit. Pages 1 and 2 should be filed within 72 hours atl Department of Health and Mental Hygiens in Important: If Item 27 is marked other than "naturel; or any Injury or other traumatic event, the Marunal Examples."		19a. Informant's Name/Relationship (Type ALGIE R. WILLIAMS/I 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral seques (see	DAUGHTER emoval from State MD •	1623 Place of Disposemetery, crer VETER	SARATO sition (Name or natory or other ANS CEM	GA COURT., (place) ETERY 01/1	FT. WASI	City or Town, State, MINGTON, M 20c. Location - City or CHELTENHAM, INS FUNERA R, MD 207	D 20744 Town, State MARYLAND L HOME			
behaviorate be executed with cartificate be executed with the cartificate between the cartificate and the cartificate in the ca	edical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last	PROSTAT Due to lor as a conseq Due to (or as a conseq Due to (or as a conseq	E CANC uence of):		dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
the di y the iched	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown	dc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregna Other (specify			23d. Date of delivery Month Day Yea				
The law requires that the has been signed boage 2 should be deta	b	Part II. Other significant conditions con	ributing to death but not res	ulting in the u	nderlying cause	given in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	the cause of death?			
10	Completed			_			24a. Was a autops perform	y prior to death?	utopsy findings availab completion of cause of 2 🖾 No			
Physician: T this certificate ral director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	ospital:	ER/Outpatier	t 3 DOA	Othor	th Check only on	e) ence 6 ∐Other(Spe	-4.			
Attending Phy r death. ector: After this by the funeral or		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. I	njury at Work?		ow injury occurred	ciry)			
9 4 7 7	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,							
Hospital 24 hours Funeral stely filled	edical	29a. Certifier 1 🔀 Certifying Phys (Check only 2 🗌 Madical Examin	ician: To the best of my kno ar: On the basis of examina	wledge, death tion and/or in	occurred at the	e time, date and place ny opinion, death occu	, and due to the carred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)			
To the Hospital within 24 hours a To the Funeral completely filled	Med	29b. Signature and title of certifier	and manner stated.	vi-	29c. Lic D23	ense number 743		9d. Date signed (Mont				
-6		30. Name and address of person who command MARTIN WELTZ M.D	. 8724 JERICH	O CITY	DRIVE	LANDOVER,	IARYLAND	20785				
Sta Registr		31. Date filed (Month, Day 2007)	32. Registraris Signa	perte	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year VIRGINIA ADAH GOUGH JANUARY 13, 17:07P M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 530 CANNON STREET KENT CHESTERTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 06/25/1951 Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2X F 55 190-38-3990 PA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 CANNON STREET 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other treumatic event, the Medical Examinan anse. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) COMPUTER GRAPHICS DESIGNER INFORMATION TECHNOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HAROLD B. GOUGH ADAH MILLER MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT G. GOUGH/BROTHER 974 ANTELOPE N.E., ALBUQUERQUE, NM 87122 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATORY 01/16/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIVER FAILURE **Physician** 3 weeks /Medical Due to (or as a consequence of) Examiner LIVER METASTASES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed years BREMST Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death signed by the at id be detached for 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ♣ No 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 25 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident within 24 hours after de To the Funeral Directo completely filled in by th 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0041587

State Registrar

DHMH 17 Rev 1/2001

20

ORIGINAL

(22 SPEARAD)

32. Registrar's Signature

HESTERTOWN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEUN AV 31. Date filed (Month, Day, Year)

			1 - For State Registrar		State	of Mary	land				ealth a		lental Hy	giene Reg. No		7	02097
i	Physici /Medic		1. Decedent's Name (First, M RETHA MAE GS		st)								2. Date of Do		200	O ^{Year}	3. Time of Death 05:15 At
	Examir		4a. Facility Name (If not instit CHESTERTOWN 5. Social Security Number	-	SING &					HESTI	Location of ERTOW	N	9 Data of Ri			of Death	
	Funeral Director		220-02-0463 Usual Residence of Deceden	1	□M 2∏F	7. Age (III	*	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D 01/10	1925 1925	5	Gou.	place (State or Foreign ntry) MD
	a-f show	ctor	10a. State 10b. Con MD KENT	unty				TERT									10d. Inside City Limits 1 ☐ Yes 2 📉 No
	h with the	ai Director	10e. Street and Number 24649 CHESTI	ERTOW	N ROAD				10f. Zip	Code 620				10g. Citizen of What Country? USA			ntry?
5-0036	be filed within 72 hours after death with the Maryland ital Hygiane. d other than "natural", or Iteme 23e or 28e-f ahow event, I'ra Mcdical Exeminar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo		12. Was Dec Armed F 1 [] Yes If Yes, G Year or I	orces? 2.1XINo ive	If Yes, specify Cuban, Mexican, Puerto					gin? (Spe i, Puerto	pecify Yes or No- p Rican, etc.) 14. Race - Americ Black, White, Specify: WHIT			etc.	
2	d within 72 ho giane. ir than "natur ire Medical	Completed	15. Dece (Specify only hi Elementary/Secondary (0-	-	de completed,) (1-4or 5+)	1	(Give life.	dent's Usu: kind of wo DO NOT u: EMAKE	rk done d se retired	ation fu <i>ri</i> ng mos	t of worki	ng	dustry			
altimore, Maryland 21		To Be C	17. Father's Name (First, Mid STEVE KENDAL	L							AUG	USTA	(First, Middle MAE JA	ACOB			
, Mar	Ith at 27 le		BOB EDLER/SO		Type, Print)			2401	.9 CH	ESTEI	RTOWN	ROA	D, CHES				
timore	permit. Pages 1 at Department of Hea Importent: If item eny Injury or othe ance.		20a. Method of Disposition 1 XBurial 2 □ Cremat 4 □ Donation 5 □ Othe	r (Specify	r)	State	CHE	STER	natory or o	rery		01/1	1/2007			-	own, State , MD
Ba	Depared Important Important Irreportant Ir		21. Signature of Funeral Sen	He	4.			J	ELLO 30 Si	VS F PEER	s of Facilit HELFE ROAD	NBEI CH	N AND N ESTERTO	JEWNA	M FI	NERA 21620	I. HOME, PA
	Physician /Medical	8 8	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or comp List only	one cause on	each line.		Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		13	Approximate Interval Between Onset and Death
8/60,	Examiner hysician and the burial-transit	dicai Examiner	cause (Disease or injury that initiated events resulting in death) Last c. Anterior club Coras a consequence of): Due to (or as a consequence of):														
P.O. Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			birth 2 🗍 nant at time	Fetal de	ath 3	Ectopic pr Other (sp						23d. Date Mor	e of deliventh	ery Day Year
	The law requires that the dise has been signed by the orage 2 should be detached	þ	Part II. Other significant con	ditions o	ontributing to d	leath but no	t resultir	ng in the u	nderlying c	ause give	n in Part I.			obacco u Yes 2	4		ne cause of death?
Vital Records,	The lar	Completed	Hystony of Canc	rus	pt f	3/1/	00	ecto	ny	fon	· lem	8	24a. Was auto perfo 1 - Yes	psy ormed2	p	Vere auto rior to co eath?	psy findings available mpletion of cause of
	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	i i	Hospital:	Inpatient	2□ER	/Outpatien	t 3 DC	A Othe			Check only		S □Othe	ır (Specif	y)
ion of	Attending Ph r death. ector: Attar th by the funeral			estigation		of Injury oth, Day Yea	ar) 28	b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y		2	28d. Describe				
DIVISION	2007	Certification:		uld not be ermined	289. Plac	e of Injury - ling, etc. (Sp	At home pecify)	, farm, str	eet, factory	, office		2	28f. Location (City or To			or Or Rura	d Route Number,
	To the Hospital or within 24 hours after To the Funeral Directory completely filled in b	edical	29a. Certifier 1 Certi (Check only 2 Medi one)	fying Ph cal Exem	ysician: To the trainer: On the trainer and mar	e best of my pasis of examiner stated.	knowle	dge, death and/or inv	occurred estigation	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and mar place, a	nner as s nd due to	tated. o the cause(s)
	.)	M	29b. Signature and title of cer	tifier C	waba	2	n)	u.1	290	License	number	89			,	(Month,	Day, Year)
	J m.		30. Name and address of per	son who	completed cau	se of death	(Item 23	3a) (Type,	Print)	reh	Stree	<i>t</i> .	Cites	Ver t	own	, W.C.	121620
4	Sta Registr		31. Date filed (Month, Day, Yo			Registrar's S	ignature	N.	Speed	5						,	

			1 - For State Registrar	State of Mar		artment of H		Mental Hygie	the property of	02098				
, e	Physici	an	Decedent's Name (First, Middle, Peggy Ann Gord	· ·				2. Date of Death Month	Day Year	A.4				
	/Medic		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Dea		7, 2007 4c. County of De	7:50 A M				
	Examin	er	131 Sunderland			Sunder			Calvert	County				
	Funeral			- C TA -	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day, Ye	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Country)					
77.2	Director		216-60-0070 Usual Residence of Decedent	1LM 2MF 53	Yrs.			Jan. 7,	1954 K	entucky				
	yland		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits				
	a-f st	ctor	MD Calvert	County	Sunderl	and				1 ☐ Yes 2X No				
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	Country?				
	ath w	ra	131 Sunderland	Drive		20689			U.S.A.					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show amy injury or other traumatic event, I'm Medical Exactical month be notified at Once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	ispanic Origin? (Sin, Mexican, Puei Specify:	to Rican, etc.)	14. Race - Arr Black, Wh Specify:					
21215-0036	2 hou	ted	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation	166	o. Kind of Busines	s/Industry				
215	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most or we	, King						
121	led w lygier her th	Cor	12 17. Father's Name (First, Middle, La	net1	Huma	n Resourc		me (First, Middle, Mai		overnment				
Maryland	ontal h	Be	Ernest Sewel	,				e Stamper	den Sumame)					
2	should Me mark mark imatic	ဥ	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a		ural Route Number, C	ity or Town, State,	Zip Code)				
	s 1 and 2. of Health al		Joseph Gordon	(Husband)				Sunderland						
Baltimore,	es 1 a of He of Hem if Item		20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other plac	э) Jan	Date 200	. Location - City of	r Town, State				
Ē	Pag tment tant: jury c		4 Donation 5 Other (Spe	cify)	Southern		dens	2007 D	unkirk, l					
Bai	permit Depar Impor Impor any in		21. Signature of Fundal Strice III					e Funeral 1						
	SCALE S		23a. Part1. Enter the disease, or co	LEC				land Blvd.		Approximate				
> 5	Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line.	in o	UBNJ	•			Interval Between Onset and Death				
*	Examiner				onsequence or,									
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):										
	sate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.										
8760,	be ex ician a burial	al E		Due to (or as a t	consequence of):									
687	ficate phys s the	edical		d										
Box (nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		70			23d. Date of d	elivery				
-	that the death certific ed by the attending p detached for use as	Physician/Med	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year				
0	at the	Phys	9 Unknown					ana Bistanhar						
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant condition	s contributing to death but i	not resulting in the u	nderlying cause give	en in Part I.	1 Tes		to the cause of death? Probably 4 □Unknown				
ec	e law r has be je 2 sh	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of				
a F								performed		s 2 No				
Vital	siciar certif iracto	Be C	25. Was case referred to medical examiner?	Hospital:	م المحالية	Othe	or	ath (Check only one)						
ō	Phys er this eral di	. To	1 ☐ Yes ZNo 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y		IL 3LIDOA	4 🗆 Nursing I	Home St Residence 28d. Describe how i		ecify)				
ion	ttending death. stor: Afte	atio	Natural 5 Pending 2 Accident investiga		(e <i>ar)</i> Injury		K? Yes 2 □No							
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determin		- At home, farm, str (Specify)	reet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,				
	spital ours a neral [29a. Certifier Certifying	Physician: To the best of	my knowledge, deat	h occurred at the tim	ne date and plac	a and due to the caus	e(s) and manner a	as stated				
	ne Hos 124 h se Fur sletely	edical	(Check only 2 Medical Ex	caminer: On the basis of ex and manner state	kamination and/or in	vestigation, in my of	pinion, death occ	urred at the time, date	and place, and du	e to the cause(s)				
	To the vithing to the comp	ž	29b. Signature applitue of certifier	1.0		29c. License	e number	29d.	Date signed (Mor	nth, Day, Year)				
)			X405 1	wwwh		10	8118	Ja	may 8	7,2007				
	12	125	30. Name and address person w	no completed cause of dea	th (Item 23a) (Type,	Print) PESTAGE	776 P.	Anno	vals 6	m 21401				
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	Signature	17 57 670	(10,17)	1014101	,,	110 21701				
	Registr		JAN	11 200/	follow St.	Roseles	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** JANUARY 21 2007 12:17 P JOANN GARRETT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) 12/20/1947 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🗓 F 219-46-1591 59 MD Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 10a. State 1 ☐ Yes 2 No Director Frederick Adamstown MID 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number an "natural", or items 23a or Medical Examiner must be USA 21710 5400 George Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Purchasing Dept. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important; If item 27 Is marked other tha any Injury or other traumatic event, the I SIAC Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Marie Carmack Bernard C. Gibson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5400 George Street Adamstown, MD 21710 Gary L. Garrett Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Olivet Cemet. 1/26/2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. 22. Name and Address of Facility Keeney & Basford P.A. F.H. Signature of Funeral/Service/License Church St.Frederick, MD M01176 106 East 23a. Part1. Enter the disease, or complications that caused the death. Do ny enter the mode of dying, such as cardiac or respiratory ar shock or heart failure. List only one cause on each line. Onset and Death late Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) ed by the s ☐ Yes 2☐ No 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has t irector, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 1□ Yes the Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA P this s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Medical Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft To the Funeral DI completely filled in certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) certifie 29b. Signature and title q ted cause of death (item 23a) (Type, Print 30. Name and address of person who comp

8

State Registrar 31. Date filed (Month, Day, Year)

JAN 2

6 2007

ΛD

Registrar's Signature

			1 = For State Registrar	State of M	aryland		artment of H		nd Menta	l Hygien		02100
			Decedent's Name (First, Middle, Last)							e of Death		3. Time of Death
	Physic		Mildred Lucill	e H. Gare	eu				JMº	-	A Pear	120 AM
	/Medi Examir		4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of		10	c. County of Death	
	LAGIIII		Fahrney . Keedy	Memorial	Home	2	Boonsh				Washing	tra
	Funeral		5. Social Security Number 6. Sex		e (In yrs. last		If Under 1 Year	If Under 24	4 Hrs. 8. Dat	e of Birth	9 Birthr	place (State or Foreign
	Director		220-26-4987	M XXF	91	Yrs.	Months Days	Hours	Min. (Mo	nth, Day, Yea il 6,1	r) Cour	D.C.
	υ		Usual Residence of Decedent						112		710	D.C.
	ylan how		10a. State 10b. County		10c. City, T	own or Lo	ocation				1	0d. Inside City Limits
	Ma	iç	Md. Washi	ngton			Hagerst	town				1 Yes 2 □ No
	r 28	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cour	ntry?
	h wit		1744 Edgewood Hil	1 Cr. Apr	t. 102			21740			U.S	3 Z
	deat	Funerai		2. Was Decedent	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba			s or No-	14. Race - Americ	an Indian,
စ	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑					Puerto Rican, (etc.)	Black, White,	etc.
9	ral',	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:			Specify:	White
5-0036	filed within 72 hours after death with the Maryland Hygiene Sther than "netural", or Items 23e or 28a-1 show ont, the Medical Evaninet must be rectified at	Completed by	15. Decedent's Educ (Specify only highest grade	ation	1	6a. Dece	dent's Usual Occupa	ition	of working	16b.	Kind of Business/Inc	dustry
2121	e. Bn "I	pje	Elementary/Secondary (0-12)	College (1-4or	5+)	lite.	kind of work done of DO NOT use retired,))	or working			
	gien gran	ő	12			Tr	avel Clei	ck.			Governmen	rt
g	al Hy al Hy soth	Be (17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First,	Middle, Maide	n Sumame)	
Maryland	should be ind Mental ind Mental is marked o	To	George C. Hi	7 7			į		Mildr	ed L.	Halbach	
a D	sho and h		19a. Informant's Nam elationship (Typ			19b. Mailir	ng Address (Street a	nd Number	or Rural Route	Number, City	or Town, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28a-1 show any Injury or other treumatic event, the Medical Evantinet must be reclifted at ance.		Lucille H. Manko (Daughter)	1744	Editownood	#i71	Cr int	1/12	Harreton	₩ M4 21740
ē	s 1 a		20a. Method of Disposition		20h Place	e of Dispo	sition (Name of	01		20c. 1	Location - City or To	m.,Md.21740 own, State
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bali		natory or other place e Nationa		an.26	C	atonsvill	e Md
altimore,	ortan Ortan Injur		21. Signature of Funeral Service License	θ			etery 2. Name and Addres		007			
B	permit. Departr Importa any Inj			D	4511111		.L. Davie		ral Hon		5 Bradbur hsburg,Ma	_
	100		22a Partt. Enter the disease, or complic		101414					DILL C	nsburg,Ma	Approximate
	and the second		shock, or heart failure. List only on Immediate Cause (Final	e cause on each li	ne.		1	g, 30011 u3 00	1			Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Hy lov	teu	Silip	Cardio	Va 500	loy	Pisea	90	3.14
	Examiner			Due d (or as	a consequen	ce of):						
ı		er	Sequentially list conditions, if any, leading to immediate	V-e	ment	vá						16 Y
	sit ed	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of):						/
þ	and -tran	Examin	that initiated events c.	Due to /or or		()						
Ď.	cian cian puria	Ë		Due to (or as	a consequen	Ce or):						
8/60,	icate be executed physician and s the burial-transit	dicai	d.									
9		Med	IF FEMALE:									
XOR	death certifi e attending od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome 1 Live birth			Ectopic pregnancy				23d. Date of delive	,
	he a	sici	1 ☐ Yes 215 No	4☐ Pregnant at 9☐ Unknown	time of death	5 □	Other (specify)				Month	Day Year
J.	at th	Phy	9 Unknown'									
ທົ	law requires that the death certif as been signed by the attending 2 should be detached for use a	by	Part II. Other significant conditions conf	inbuting to death b	ut not resultin	g in the ur	nderlying cause give	n in Part I.	236	. Did tobacco	use contribute to th	e cause of death?
בס	w require been sig should b	led								1 ☐ Yes 2	2 ☐ No 3 ☐ Prob	ably 4 Mnknown
ecord	aw ras be	Completed							248	. Was an	24b. Were autor	osy findings available
T	siclen: The law certificate has b irector, page 2 s	E o							_	autopsy performed?	death?	npletion of cause of
Vita	en: tiflica tor. p	O	25. Was case referred to medical					26 Place of	f Death Check	Yes 2 No	1 □ Yes	2 No
	Physiclen: this certific ral director,	o B	examiner? 1 ☐ Yes 2 Ş No	ospital:	nt 2 EP/	Outpatien	Otho	_			6 ☐Other (Specify	
Ö			27. Manner of Death	28a. Date of Inju	ry 281	b. Time of	28c. Injury	at		cribe how inju)
0	th. : Afte	it i	1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y Year)	Injury	Work¹ M 1 ☐ Y	? es 2.∐No	,			
UNISION	al or Attending safter death. I Director: After d in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home	, farm, stre	eet, factory, office		28f. Loca	ation (Street a	nd Number or Rural	Route Number
2	7 0 2 0	erti	4 Homicide	building, etc	c. (Specify)	,,	out, ractory, omoo			or Town, Stat		, 10410 . (4)11001,
	spital or ours afte nerel Dia filled in	O	29a. Certifier 1 Certifying Physi	cian: To the best	of my knowled	dne death	Cocurred at the time	date and r	place, and due	to the source/o	.\ and	nt o al
	To the Hospital or within 24 hours af To the Funerel D completely filled in	edical	(Check only 2 Medical Examin	er: On the basis of and manner sta	examination	and/or inv	estigation, in my op	inion, death	occurred at the	time, date an	d place, and due to	the cause(s)
	ithin o the	Me	29b. Signature and title of certifier	- Indilior Sta			29c. License	number		29d Da	ate signed (Month, L	Day, Year)
	F ≱ F 8											
								323	\$	10/-	55-500	+
	2		30. Name and address of person who con Khalid M. Waseem M	npleted cause of d. $D_{\bullet} = 1.126$	eath (Item 23: Opa 7 (a) (Type, I C t . H	_{Print)} Lagerstown	Md.	21740			
			31. Date filed (Month, Day, Year)				J =	-				
	Sta Registr	259		107 July	ar's Signature	1 1	DRAGE S					
	11091511		atility of Co	VI 100 100	March State	3	AND CHANGE					

			For State Registrar	State of Mary		artment of F		, ,	iene 19. No.2 0 0	7 02101
			1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
	Physicia /Medica			Violet Gun	ter				07 200	
	Examine		4a. Facility Name (If not institution, give	street and number)	, ,	4b. City, Town, o	r Location of Death		4c. County of	
			PENINSULA REGIONAL N	regical Cent	4	- Sa	disbull			OMICU
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
	Director		218-24-4451	80) Yrs.		141	June 6,	1926	Maryland
7	pur *	-	Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
467	sho	5			•					1 ☐ Yes 2 ⊠ No
3-	Ne N	Director	MD Wicomi	.co	Quantic			1	On Citions of 14th	
3	with the	ä		J _		10f. Zip Code		1	og. Citizen of Wha	at Country?
te 2/2	e 23	srai	21790 Stephenfiel	12. Was Decedent Ever	in II S 12	2185		neify Ves or No-	USA	American Indian.
15	Br de	Funerai	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	11 0.3.	If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		White, etc.
36	rs af	Š	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	Black
1,4cc 215-0036	within 72 hours after deeth with the Maryland ene. then "naturel" or Iteme 23a or 28a-f show the Madical Examinar must be notified at	Completed by	15. Decedent's Edu		16a. Dece	dent's Usual Occur	pation		16b. Kind of Busin	
\$ E	n n	piet	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retire	during most of work d)	ing		,
35	r the	E	Elementary/Secondary (0-12)	College (1-4or 5+) + 1	Sec	urity Car	otain		Globe Se	curity Co.
	othe other,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, N	faiden Sumame)	
Se Para	Mental Mental arked o	10 B	Roosevelt Armst	rong			Marv	Alice Jo	seph	
T a	and No.		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ng Address (Street	and Number or Run	al Route Number,	City or Town, Sta	ate, Zip Code)
2≥	alth a		Rosa Leath/Daughte	er	P.O	Box 132	- 21790 Ste	ephenfield	LA, Quant	21856 ico, Maryland
Jo C	of He of He roth		20a. Method of Disposition		Ob. Place of Disp	osition (Name of matory or other pla		Date 2	20c. Location - Ci	ty or Town, State
⊃Ĕ	Pages nent of ont: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Salisbury		· 1	13, 07 _S	alisbury	, Maryland
U 10 Baltimore	permit. Pages 1 and 2 should be filed within Department of Health and Menial Hygiene. Importent: If item 27 is marked other then eny injury or other treumatic event, the Mace.	1	21. Signature of Funeral Service Licent			2. Name and Addre		alisbury, I		
ä	29 E 2 8		Lowetta G.	Salley	,	Tolley Men				ey Road 21801
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	cations that caused the	death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final	HOTE	100014	10710	Vascul	AN /), CEACO	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co		10110	,5		13671	
	Examiner									
		Der	if any, leading to immediate	Due to (or as a co	nsequence of):					
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	s						
760,	e be executed sicien and e burial-transit		resulting in death) Last	Due to (or as a co	insequence of):					
376	~ ~ ~ .	Ical		d						
68 89	ing p	Physician/Med	IF FEMALE:							
30	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1☐Live birth 2☐	Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	
<u>.</u>	e de the e	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time 9 Unknown	of death 5	Other (specify)				PPLICABLE
9.	d by	ર્	Part II. Other significant conditions co.	attibuting to death but on	at coculting in the	andorbijon souso su	ion in Dark I	220 Did tob		ute to the cause of death?
S,	signe I be d	Completed by	And the second s	MELI 170		IDF IT	remini r anti.			Probably 4 Munknown
20	neen houlk	etec			7	THE IT				
ec	s law hes b	du						24a. Was ar autops	y / pric	re autopsy findings available or to completion of cause of
=	cete	Š						perform	No 1□	ath?]Yes 2□No
<u> </u>	Sertifiector	Be	25. Was case referred to medical examiner?	lospital:		04	26. Place of Deat	h (Check only one	9)	
ot o	Phys this al dir	ဥ	1 Yes 2 No	1 Unpatient	2 PER/Outpatie	nt 3 DUA		me 5 Reside		
Ę	After	lo l	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) Injury	Wo	rk? Yes 2 □ No	Zod. Describe no	w injury occurred	
isi	death death tor:	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm of			28f Location (St	reat and Number	or Rural Route Number,
Division of Vital Records, P.O. Box	atter Direct in by	Certification:	4 Homicide determined	building, etc. (S	Specify)	reet, factory, office		City or Town	, State)	or nata noute Number,
_	ours ours perel filled		29a. Certifier 1 Certifying Phy	sician: To the best of m	v knowledge dea	h occurred at the ti	me date and place	and due to the ca	use/s) and mann	er as stated
	To the Hospital or Attending Physician: The law requires that the death cartifica within 24 hours after death. To the Funeral Director: After this certificete has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medicai	(Check only 2 Medical Exami	ner: On the basis of exa and manner stated.	amination and/or in	ivestigation, in my	opinion, death occur	ed at the time, da	ite and place, and	d due to the cause(s)
	ompl	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (i	Month, Day, Year)
	->) d	, 5 A	20	1	50755	3)	01/0	7/2000
,	100		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type	Print)			0//0	1/200/
	10		CHARLES O. FOLA	SHADE M	p 108	PINEBL	MFG RI	SAL	ISBURY	MD 21801
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,				
	Registra	ar	JAN 112	2007	, K	boorte				

Physician /Medical Examiner The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician

Baltimore, Maryland 21215-0036

Be မှ within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral. Certification:

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 40324

29d. Date signed (Month, Day, Year)

JANUARY 8, 2007

State Registrar

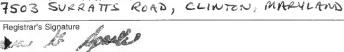
31. Date filed (Month, Day, Year) JAN 2 6 2007

29b. Signature and title of certifier

JOD 21E



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



the Hospital or Attending Physician:

this

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Patricia D. Harris /Medical January 2007 6:25 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5013 Boydell Avenue Oxon Hill Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🏋 F Yrs. Director 62 578**-**58-2939 Nov. 26, 1944 Wash. DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1X□Yes 2□No Director Maryland Prince George's Oxon Hill 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5013 Boydell Ave. 20745 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Management Analyst</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Sam Williams Alma Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health :: If Item 27 / or other t Dena R. Harris/Daughter 5013 Boydell Ave., Oxon Hill, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Memorial Cem. 1/16/2007 Suitland, MD 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Ent. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or conntion resulting in death) **Physician** Metastatic Cancer of Adrenal Gland /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) Division or VItal Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ∭Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 212 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou **To the Fune** completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State

31. Date filed (Month, Day, Year)

JAN 1 1 2007

32. Registrar's Signature

Susan H. Houseman, M.D. 2100 Pennsylvania Ave., NW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DC9603

January 10, 2007

Wash., DC 20037

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:10 а м January 21, 2007 Kemp /Medical Houck. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) 89 Yrs If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth April Day (Year) 1917 9. Birthplace (State or Foreign Complex) Jand **Funeral** 220-30-8830 1X M 2□ F Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f ehow the Medical Examiner must be notified at Maryland Frederick Frederick TYDYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Lindfield Drive 21702 U.S.A. death Funeral iteme ; 12. Was Decedent Ever in U.S. Amed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian filed within 72 hours after 1 Never Married 2 Married I ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2X No Specify: White Completed by 3X Widowed 4 □ Divorced 'naturel', Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Farmer Farming permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked othe eny flutry or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tolbert Kemp Houck Nora Haugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Jean Houck/Daughter 1001 Lindfield Drive, Frederick, MD 21702 20b. Place of Disposition (Name of competery, cramatory, or other place)
Faith United Church of Christ Cemetery

Jan. 27, 2007 Frederick, MD. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fluneral Service License ²² Keeney and Bastord Funeral Home Muland 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Subdural Hematoma Days /Medical Due to (or as a consequence of): Examiner Intraventricular hemorrhage if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 days Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinson's Disease; Dementia; COPD 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 X Yes 2 ☐ No this After this 28a. Date of Injury (Month, Day Year) Jan 11,2007 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1645 1 Natural 5 Pending death. Fell while walking 1 Yes 2 No investigation after death | Director: / d in by the f 2X Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

Nursing Center 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel DI completely filled in 7401Willow Rd, Frederick, MD 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37197 January 23, 2007 of leath (Item 23a) (Type, Print) 15 West Seventh Street, Frederick, Maryland 21701-4501 Alan H. Rohrer, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State I Children

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	laryland .		artment rtificate			nd Men	tal Hygie	4001	02105	
			Decedent's Name (First, Middle, Las.)	")						2. [Date of Death		3. Time of Death	
H	Physici /Medio		Fernando	Hernand	ez-Moi	rale	s			٥	Jan.1,	2007 Year	8:15p M	
	Examir		4a. Facility Name (If not institution, give						ocation of I	Death		4c. County of Death		
			4730 Bradley						Chas			Montgom	ery	
L	Funeral		5. Social Security Number 6. Se	x 7.A AgM 2□F	ge (In yrs. last	birthday) Yrs.	If Under 1 Months I	Year Days	If Under 24 Hours	Min.	Date of Birth Month, Day, Ye	ari Cou	place (State or Foreign ntry)	
	Director		Usual Residence of Decedent	-	53					<u>L</u>	Dec.14	, 1958 M	exico	
	yland		10a. State 10b. County	-	10c. City, T					-			10d. Inside City Limits	
	e-f el	ctor	Md Montgom	ery	Che	evy	Chase						1 ☐ Yes 2 🙀 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel', or Items 23a or 28e-f ehow eny highly or other traumatic event, Ite Medical Examinational be notified at ance.	Director	10e. Street and Number 4730 Bradley	Blvd An	+ A5		10f. Zip C	ode 081	5		_	Citizen of What Cou	ntry?	
	leath	Funeral	11. Marital Status	12. Was Decedent		13				n? (Specify		14. Race - Ameri	can Indian	
ഗ	or Hen	Fun	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☐	?	1	Was Deceder If Yes, specify					Black, White,	etc.	
8	rel', c	1 by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			1 StYes 2	.] No	Specify: [V	Mexic	an	Specify: Wh:	ite	
5-(72 h natu	Completed	15. Decedent's Edu (Specify only highest grad		1	6a. Dece (Give	dent's Usual (kind of work DO NOT use	Occupati done du	ion ring most o	of working	16t	. Kind of Business/Ir	ndustry	
12	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)		<i>DO NOT use</i> intena					Building	as	
d 2	Hygie Other ant,	Co	12 17. Father's Name (First, Middle, Last)							s Name (Firs	st, Middle, Maid			
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ary	2 should and Men is marks aumatic	_	19a. Informant's Name/Relationship (T)	rpe, Print)	1	19b. Maili	ng Address (S	Street an	d Number o	o <i>r Rural R</i> ou	ute Number, Ci	ity or Town, State, Zip	Code) 20113	
	and 2 ealth 127 IT		Diana Gonzalez/	Friend			_		Bra	nch I	Or. #2	02 Oden	ton, Md	
altimore,	Pages 1 nent of Hi int: if Iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑	Removal from State	ceme	etery, crei	sition (Name natory or othe	r place)		Date	п	Location - City or To	own, State Estado de	
Ë	t. Partmen		4 ☐ Donation 5 ☐ Other (Specify)		Pan	De (Jard: Drient	e	- 1	16/0	/	Mexi	co	
Ba	permit. Departn Importa eny inju		21. Signatur Funeral Service Licent				HTLTF 241 C	Address 'O I II	RTNA mbia	LDI	FUNERA	L SERVIC	E,P.A. g,Md20910	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause ne cause on each I	d the death. [Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Core	500/1	050	UK	0	CCic	den			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):						,		
		- L	Sequentially list conditions,	Due to (or as	a onsequence	ce of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	22.00	1/2	ride		-		٠				
o,	exec	Еха	resulting in death) Last	Circle to (or as	a consequent	ce of):	21143							
8760,	icete be executed physicien and s the burial-transit	dical		d.										
	entific ding p	Mec	IF FEMALE:	20 - 1/								1	are the second	
Box	eath certific attending p	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal dea	ath 3 [Ectopic preg					23d. Date of deliver	ery Day Year	
o	The law requires that the death certific sie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	it time of death	1 5	Other (spec	<i>†y)</i>						
a.	res that igned by be deta	уРһ	Part II. Other significant conditions co	ntributing to death t	out not resultin	g in the u	nderlying cau:	se given	in Part I.	2	23e. Did tobaco	co use contribute to t	he cause of death?	
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ř	Physician: The lav r this certificete has ral director, page 2 :	E O	COOC CAN	back	1	1./	C				autopsy performed Yes 2	? death?	mpletion of cause of	
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Division of	ling P	ino.	27. Manner of Death 1 Salatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28t ay Year)	b. Time of Injury		Injury a Work?			Describe how in	njury occurred		
<u>s</u>	death ctor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of In	iun At homo	farm etc	M		s 2□No		conting /Ctract	and Number or Rura	10-4-11	
2	s efter al Dire ad in b	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify)	, idilli, su	eet, ractory, o	IIICe		201. 6	City or Town, St	tate)	ar Houte Number,	
	To the Hospital or Attanding Physician: within 24 hours deler death. To the Funeral Director: After this certifion completely filled in by the funeral director.	Medical	29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of and manner st	of examination	dga death and/or in	occurred at vestigation, in	he time, my opin	, date and p nion, death o	Jace, and di occurred at	te to the cause the time, date a	e(s) and marmer as s and place, and due to	lateu. o the cause(s)	
	To the	Me	29b. Signature and title of certifier				29c. L	icense n	number		29d.	Date signed (Month,	Day, Year)	
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-			30. The and address of person who co			a) (Type,					/	1007	1::	
			CONTRACTOR OF THE PERSON NAMED IN COLUMN 1	ain MD			nnect	icu	ıt Av	enue	Kensi	ngton,Md	20895	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 1 200		rar's Signature		2400 2							

		•	For State Registrar	State of	f Marylan		artment of H tificate of I		nd Mental Hyg	giene Reg. No. 007	02106
. 6	Physicia	an	Decedent's Name (First, Middle						2. Date of Dea Month	Day Yea	3. Time of Death 7 23:37M
	/Medic	al	FRANCISCO 4a. Facility Name (If not institution	S. HERNANDE			4b. City, Town, or	r Location of I	Death	4c. County of De	
-	Examin	er	WASHINGTON ADVE					MA PARK		MONTGON	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt Min. (Month, Da	h 9. E	Sirthplace (State or Foreign Country)
N. T.	Director		578-52-3697	1⊠M 2□F	88	Yrs.	Months Days		OCTOBER		EXICÓ
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl febo	ō	MARYLAND PRINCE	E GEORGE'S		ну	ATTSVILLE				1 🖔 Yes 2 🗌 No
	28e	rec	10e. Street and Number	- CLORED D		111.	10f. Zip Code			10g. Citizen of What	Country?
	h with	ai D	1836 METZEROTT	ROAD, APT.	609			20783		U.S	S.A.
	ems a	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13.	Was Decedent of H	lispanic Originan, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		nencan Indian,
36	or It	by Fu	1 Never Married 2 Mar	If Yes. Giv	/e		1⊠Yes 2□No	Specify:		Specify:	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f ehow dical Examiner must be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or Date of the Year or Date of The Year o	ates:	16a. Dece	dent's Usual Occup		ÆXICAN	16b. Kind of Busines	WHITE
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ם	be filed ital Hygi od other event, I	Be (17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle,	Maiden Surname)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Medical Examinar must be notified at	To	JESUS HERNAI						INIDAD SOLIS		
Mar	12 sh h and 7 is rr iraur		19a. Informant's Name/Relations						or Rural Route Numbe		
	1 and 2 Health em 27		CARMEN T. H. AGU:	LLEKA - DAUG	20b. F	lace of Dispo	sition (Name of		, SILVER SPRI	NG MARYLAND 20c. Location - City	
Baltimore,			1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State	emetery, crei	natory`or other plac EAVEN CEMET		/12/2007		NG, MARYLAND
薑	그 본 원 글 .		21. Signature of Funeral Service			22	. Name and Addre	ss of Facility			NG, MARILAND
ñ	Depa Impo eny ii		1 (Imanda	Lude	was				AL HOME, INC. AVENUE, SILV		ARYLAND 20904
4			23a. Part1. Enter the disease o shock, or heart failure. List	complications that o	aused the deat	h. Do not ent	er the mode of dyin	ng, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Sa	ntic	Shoe	K.			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	uence of):	7	>	4		
	LAGIIIIICI	_	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	John to	on (nour	nonce		
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9	death certificate e attending phys id for use as the	Medi	IF FEMALE:								
Вох	leath certifica attending ph I for use as ti	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregna pirth 2 🗆 Feta	Ideath 3[Ectopic pregnancy	/		23d. Date of o Month	delivery Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9⊟Unkn	nant at time of d own	eath 5	Other (specify)				
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8	iw require s been si should l	lete	acute	Rouge	Fa	ilu n	·. /	•	24a. Was		autopsy findings available
Vital Records,	0 - 0	Completed	Blood	Con 6	unon	ue_	with	Short	— autop perfo 1 ☐ Yes		
ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place o	f Death Check only o	-	
of <	Physician: this certific	2	1 ☐ Yes 2 🗗 No			ER/Outpatier		4 111013	ing Home 5 🗆 Resid		pecify)
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Division	tend death tor: the	lcat	3 ☐ Suicide 6 ☐ Could		of Injury - At h	ome farm str	reet, factory, office	Yes 2 □No		Street and Number or	Rural Route Number.
Οį	in the	Certification;	4 Homicide determ		ing, etc. (Specif		out, tastory, omoc		City or Tov	vn, State)	
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	aic	29a. Certifier 1 Certifyi	ng Physician: To the	best of my kno	wledge, deat	h occurred at the tir	ne, date and	place, and due to the	cause(s) and manner	as stated.
	the Horin 24 the Fu	edical	(Check only 2 Medical one)	and man	ner stated.	ition and/or in	vestigation, in my o	pinion, death	occurred at the time,	date and place, and d	lue to the cause(s)
	Vith To t	Σ	29b. Signature and title of certific	9			29c. Licens	(n-		29d. Date signed (Mo	
•	4		1	6			7	1186) /	1/900	<i>/</i>
	ř		30. Name and ad flass of person	ONEV ZINTO				יישידוים (216 DOGGGGG	TE MADS/T AST	20052
400	Sta	te	31. Date filed (Month, Day, Year	32	egistrar's Signa		MOULU KOAL	, SULLE	216, ROCKVII	LE, MAKYLANL	20852
	Registi		JAN 11	2007	wer 1	K de	ale				

DHMH 17 Rev 1/2001

Registrar

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JAN

			1 - For State Registrar	State of I	Marylar	-	artmen rtificat			ind Me		jiene og. No.	07	02108	
			Decedent's Name (First, Middle, Last))							2. Date of Dea	th		3. Time of Death	
н	Physici /Medio		Ruth E.	Haines							Month January	Day 5, 20	007	4:03 A M	
	Examir		4a. Facility Name (If not institution, give		er)		4b. City,	Town, or	Location of	f Death		4c. County of Death			
			11400 Mt. View R				1	ascu				Mon	Montgomery		
	Funeral		5. Social Security Number 6. Security Number 10	7. M 2 🖾 F	Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day	: Year)	hplace (State or Foreign untry)		
	Director		Usual Residence of Decedent			113.					July 28	, 191	9 Ma	ryland	
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	Man	tor	Maryland Montgom	ery	Da	mascus								1 ☐ Yes 2 🛣 No	
	or 284	irec	10e. Street and Number				10f. Zip	Code				0g. Citizen	of What Co	ountry?	
	23a	Funeral Director	11420 Mt. View R	oad	_			20	872			U.S	.A.		
	des des	nuel	THE MAINE STATES	12. Was Decede Armed Force 1 ☐ Yes 2	nt Ever in U ş?	.S. 13.	Was Deced	lent of His	spanic Orig	jin? (Spec , Puerto R	ify Yes or No- ican, etc.)		Race - Ame Black, White	ncan Indian, e, etc.	
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give		1	1□Yes		Specify:			Spe	cify:		
Ş	hour	ed t	15. Decedent's Edu	Year or Date	s.	16a. Dece	dent's Usua	I Occupa	tion			16b. Kind o		ite	
5	n n	Completed	(Specify only highest grade	e completed)	- F.\	(Give	kind of wor DO NOT us	rk done d se retired)	urina most	of working	7				
25	d with	E O	Elementary/Secondary (0-12)	College (1-4d)r 3+)	Home	maker					Ow:	n Hom	e	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. • marked other than "natural", or iteme 23e or 28e-f ehow umatic event, the Madical Expiding Livel be notilial at	Bec	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (First, Middle,	Maiden Surr	ame)		
<u>X</u>	Ment Ment Brke Bric	2	James Washingto	n Watki	lns				A	ddie	Eliza	beth	Ship	ley	
Jar	2 short and is m		19a. Informant's Name/Relationship (Ty								Route Number				
e d	and Health om 27		Lewis E. Haines -	Son	205	1140 Place of Dispo	0 Mt.		w Roa	d, l	Damascu 		-		
وت	if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from Sta		cemetery, crer	natory or o	ther place	9) N T		9, 2007	20c. Locatio		, Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-1 show strip injury or other traumatic event, the Madicial Extending must be notified at once.		4 Donation 5 Other (Specify)								, 2007	Daile	15Cu5	, maryrand	
Ba	Depa impo eny is		21. Signature of Funeral Service Lisensee Cluams 22. Name and Address of Facility Molesworth-Williams P.A., Funeral 26401 Ridge Road, Damascus, Maryl											me d 20872	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause on each	sed the deat t line.	h. Do not ent	er the mod	e of dying	, such as c	cardiac or	respiratory arr	est,		Approximate Interval Between	
E	Pnysician	r n	Immediate Cause (Final disease or condition	Brea	st Ca	ncer								Onset and Death 3 Years	
	/Medical resulting in death) Due to (or as a consequence of):														
		- I	Sequentially list conditions, it is a cause. Enter Underlying Cause, Disease of injury												
	ned nsit	nin.													
Ć	execun and ial-tra	Examiner	that initiated events resulting in death) Last		as a conseq	uence of):									
8760,	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	cal		1.											
89	ntifica ng ph as th	Physician/Medical	IE EEMALE.												
Вох	ith ce tendii or use	an/	230. Was decedent program	3c. If yes, outcor 1 ☐ Live birth			Ectopic pr	egnancy					Date of deli		
E	that the death certific ed by the attending p detached for use as	sici	in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	4☐Pregnant 9☐Unknown			Other (sp.						Month	Day Year	
<u>о</u> .	d by		Part II. Other significant conditions cor	tobuting to doath	but not son	uitina in the			- i- O1	_	OOO Did to			Manager of decays 0	
Division of Vital Records,	w requires to been signed should be considered.	1 by		arkinson			idenying ca	ause give	n in Part I.					the cause of death?	
Ö	v requ	etec				Беаве				_					
Be	has ge 2	Completed	Hypothyroid								24a. Was a autops perfore	v	b. Were au prior to d death?	topsy findings available completion of cause of	
ā	in: The	e Co	25. Was case referred to medical								1 ☐ Yes	2 ZANo	1 🗆 Yes	2 No	
5	s cert irecte	To Be	examiner?	lospital:	tient 2	ER/Outpatien	* 30 00	Othe			Check only on 5 ☐ Reside		Dah /C	city) Son's	
ō	Attending Physician: r death. ector: After this certifice by the funeral director.	Ë	27. Manner of Death	28a. Date of li		28b. Time of		Bc. Injury Work	4 (140)		d. Describe h			Home	
0	ath. r: Aft	atlo	1 Matural 5 Pending 2 Accident investigation	(MONIN, I	Jay rear)	Injury	М		es 2 □ N	10					
<u>≥</u>	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building.	Injury - At he	ome, farm, str	eet, factory	, office		28	f. Location (Si City or Town		mber or Ru	ral Route Number,	
	ital or urs afte rei Dir lled in	Cer													
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a Certifier 1 La Certifying Physics (Check only one) 2 Medical Examin	ner: On the basis and manner	of examina	wladge death ition and/or inv	estigation,	in my op	e date and inion, death	plane an h occurred	d dua to the di Lat the time, d	tues(e) and ate and plac	e, and due	ctuted. to the cause(s)	
	To the within: To the comple	Me	29b. Signature and title of certifier			-	29c	License	number		2	9d. Date sig	ned (Month	n, Day, Year)	
			Donelso	2				D219	936			Janua	ry 5,	2007	
L	1		30. Name and address of person who co	mpleted cause o	f death (Iter	n 23a) (Type,	Print)								
			Andrew O. Donelso	on M.D.	65C	Thoma	as Jol	hnson	n Driv	ve,	Freder	ick, M	lary1a	ınd	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 12 20	07	strars Signa	B A	radi	•							

			1 - For State Registrar	State of M	aryland	-	artment of F		d Mental Hy	giene Rog. No	7 1111 /	02109
	Physici		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Da	y Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	1 0 1			4b. City, Town, o		eath		. County of Deat	. 1
	Funeral		5. Social Security Number 6. Se		je (In yrs. la	st birthday)	If Under 1 Year			th	Ance An	hplace (State or Foreign untry)
	Director		216-20-0960	ØM 2□F 79	9	Yrs.	Months Days	Hours M	in. (Month, Da Mar 24	-		intry) insylvania
	yland		Usuel Residence of Decedent 10a. State 10b. County	 .	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Sa-fsi	ector	MD Anne Arı	ındel			Loth	ian				1 ☐ Yes 2 🙀 No
	3a or 2	i Dir	10e. Street and Number 5590 Greenock Roa	h.d			10f. Zip Code 2071	1		_	tizen of What Co JSA	untry?
	r death	ner	11. Marital Status	12. Was Decedent Armed Forces?				lispanic Origin?	(Specify Yes or No erto Rican, etc.)		14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28s-f ehow fa Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∑Yes 2 ☐ If Yes, Give Year or Dates:		46	☐Yes 2M No	Specify:			Specity: Whi	
21215-0036	72 hou	eted	15. Decedent's Edi (Specify only highest grad	ucation		16a. Deced	lent's Usual Occup	during most of v	working	16b. K	(ind of Business/	
121	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		oo NOT use retired ronic en			Met	tro mass	transit
nd 2	al Hyg a other	Be C	17. Father's Name (First, Middle, Last)			CICC	LOILE	_	lame (First, Middle			OLULIO I
Maryland	d Ment marked matic	ļ	Ashby Lee Hic	rdon	- X	10h Mailie	a Address /Ctons	Ann	Rosalie Rural Route Numb		onan	F- 0- 4-1
	alth an 27 le i		Medora H. Shephero		er				Lothian,			ip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel; or Items 23a or 28a-f show appring to other traumatic event, the Macical Examination at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	Cel	metery, cren	sition (Name of natory or other plac		Date		ocation - City or	
Ē	nit. Pa ertmen ortent: Injury	19	4 ☐ Donation ² 5 ☐ Other (Specify, 21. Signature of Europeal Service Licens		Met	-	tan Crem		1-09-07	Al	exandria	a, VA
Ba	Depermine Depermine Impo		William Z.	Gios	_				lome, P.A.	., 0	wings, N	1D 20736
н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each li	ne.			ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	ř T	Immediate Cause (Final disease or condition resulting in death)	aN	-	he in	nur					Month
	Examiner		Sequentially list conditions.	b	u 001100q30	31100 017.						
	pet usit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	shee of):						
oʻ	te be executed ysicien and te burial-transit		that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):						
8760,	4 5	dical		d								
Box 6	death certifica e attending ph ed for use as t	in/Me	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23d. Date of deli	very
P.O. B	es that the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown			Other (specify)				Month	Day Year
ď.	Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	by Ph	Part II. Other significant conditions co	ntributing to death b	out not result	ting in the ur	iderlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
ords	w require been sig should b	ted b							_ 10'	Yes 2	□No 3□Pro	obably 4 Mnknown
Rec	The law as the page 2 st	Completed							24a. Was autop		24b. Were au prior to d death?	topsy findings available completion of cause of
ital	iclen: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of D	1 ☐ Yes Death <i>Check only</i> o		1 □ Yes	2 XNo
ot <	Physic this ce al direx	ToB	examiner? 1 Yes 2 No 27. Manner of Death	lospital: 1 ☐ Inpatie		P/Outpatien		4 🗀 (40) 5)(1)	Home 5 Resid			afy)
on	nding ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	28b. Time of Injury	28c. Injur Wor M 1	yai k? Yes 2∐No	28d. Describe I	now inju	ry occurred	
Division of Vital Records,	To the Hospital or Attending Physicien: while 24 hours after deals as after deals. To the Funeral Director: After this certification properties to the funeral director, to ompletely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tou	Street ar	nd Number or Ru e)	ral Route Number,
_	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier (Check only (Check sonly (Che	sician: To the best	of my know	ledge, death	occurred at the tin	ne, date and pla	ice, and due to the	cause(s) and manner as	stated.
	To the H within 24 To the F complete	Medicai	one) 29b. Signature and title of certifier	and manner sta	ated.	on and/or my	29c. Licens				te signed (Month	
	8 1₹ 1		> task	~ Phee	MD		Do	12/42	79		Martin	7
11	541		30. Name and add s of prison who c	ompleted cause of d	death (Item 2	23a) (Type, I	Print)	1. 2	Anapilis			
	J7 Sta	te	31. Date filed (Month, Day, Year)	32. Registr	s Signatu	ine Jah	e 16 a 30	1HC 5UJ	Mucholy	M	2140	
	Registr		JAN 1	2007 ▶	College !	K	book					

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			For State		State of	Maryl			rtment of F tificate of	lealth and I	-					
	S. AV		Registrar 1. Decedent's Name	e (First Middle 1:	ast)			Cei	illicate of	Deain	2. Date of De	Reg. No.	200	17	3. Time of E	Death .
	Physici										Month Januar	Day		ear 7	8:22	- M
j.	/Medic Examin		Marie 4a. Facility Name (/		Jean-Phi ve street and num		e		4b. City, Town, o	or Location of Death			County of		0:22	
À.	LXamii		1131 117	niversity	, Blud v	√ Z\	n+ 1	102	Silv	or Sprine	•		Mont	COM	oru	
	Funeral		5. Social Security N	lumber 6.3	Sex 1 □ M 2 🔀 F	7. Age (In	yrs. last bir	thday)	If Under 1 Year Months Days	er Sprinc If Under 24 Hrs: Hours Min,	8. Date of Bir (Month, Da	th ıy, Year)	9	. Birthpl	ace (State or	Foreign
h	Director		579-74-33 Usual Residence of	300	T IWI Z IZAT		75	Yrs.			June 14	, 19	31	Coun Hai	ti 	
	land ow		10a. State	10b. County		10c	. City, Towr	n or Loc	cation		·····			10	Od. Inside City	/ Limits
	Many a-f sh fied	tor	Maryland	Montgo	mery		Si	lve:	r Spring						1 ☐ Yes	2 XNo
	th the or 28% e not	Directo	10e. Street and Nur	mber					10f. Zip Code			10g. Citi:	zen of Wha	at Coun	try?	
	23a ust b	ral	1131 Ur	niversity	T					20902				JSA		
	er dea Items ner m	Funeral	11. Marital Status		12. Was Dece	ces?	in U.S.	13. V	Vas Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.))-	 Race - Black, 	America White, e		
30	rs aft I", or I xamir	by F	1 ☐ Never Marr	ied 2√ Married 4 Divorced	1 □ Yes If Yes, Give Year or Da	9		1	□Yes 2√2 No	Specify:			Specify: E	lac	k	
2-003p	2 hou atura cal E			15. Decedent's E	ducation		16a.	Deced	ent's Usual Occup	pation		16b. Kii	nd of Busir	ness/Ind	lustry	-
7	thin 7 e. an "n Medi	Completed	Elementary/Seco	ondary (0-12)	ade completed) College (1-	4or 5+)		(Give i life. D	kind of work done OO NOT use retire	during most of wor d)	king					
7	ed wii ygien ier th t, the	S				5+		Ac	countant				ernme	nt		
and	be fill ntal H ed oth	Be	17. Father's Name	, , ,	t)					18. Mother's Nan			,			
3	nould d Mer narke natic	은	Elie Cyr	•	/Time Brint\ = F	Jucha	nd tob	Mailin	a Addraga (Ctract	and Number or Ru	nancie C			-1- 7'-	0-4-MD	20002
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စ် .	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fiem 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp			20	b. Place of	Dispos	sition (Name of	ty Blvd,	Date	20c. Lo	02 Scation - Cit	ilv y or To	er Spr wn, State	ing,
аппо	Page: ient o nt: if i			☐ Cremation 3 [5 ☐ Other (Speci		tate G			natory or other plac eaven Cei		Jan. 13 2007		war c	hri	ng, Ma	rvlan
a	permit. Departm Importa any Inju		21. Signature of Fu					F 22	Name and Addre	es CoTig liyns					ng, na	Ly Lan
<u>מ</u>	8 8 8 8		de	- me	Doda.	7		500	O Univer	sity Blvd	l, W., S	ilve	r Spr	ing	, MD 2	0901
			shock, or hila	art failure. List only	nplications that ca one cause on ea	d the o	death. Do r	not ente	er the mode of dyi	ng, such as cardiad	or respiratory a	rrest,			Approximate interval Betwo	/een
F	hysician		Immediate Cause (disease or conditio resulting in death)	(Final on	d		ancer								Oliset and D	
1	/Medical Examiner		roodiang in dodan		Due to (d	or as a con	sequence	of):								
		er	Sequentially list co	nditions, nmediate	b. — Due to (c	or as a con	sequence	of):						-		
	executed n and iat-transit	Examiner	cause. Enter Under Cause (Disease of that initiated events	erlying	c											
	e exe ian ar ıria!-tı		resulting in death) l	Last	Due to (d	r as a con	sequence (of):								
00/00	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical			d									+		
×	ding p	/Me	IF FEMALE:		23c. If yes, outo	ome of or	eanancy									
<u> </u>	atten for us	cian	23b. Was deceden in the past 12	months?		rth 2 🗀	Fetal death		Ectopic pregnancy Other (specify)	у		2	23d. Date o Month		•	ear
j į	the d by the ached	ysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□Unkno											
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cords,	equire en sig ould b										10	Yes 2	□ No 3] Proba	ably 4 □Uı	nknown
ည် မ	law ras be 2 sho	Completed									24a. Was		24b. We	re autop	sy findings a	vailable
ב =	I he	Con									perfo 1∐ Yes	rmed?	dea	th?	2□ No	
VII a	ician certific ector,	Be	25. Was case refer examiner?		Hospital:				Oth	26. Place of Dea						
5 7	ral dir	은	1 ☐ Yes 2√3		28a. Date o		_	tpatient Fime of	3 DOA O	ner: 4 ☐ Nursing H	ome 5 XResi 28d. Describe	dence 6	Other	'Specify)	
	h. After funer	tion	1 Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month	i, Day Yea		njury	28c. Injui War M 1 □	rk? Yes 2∐No	200. Describe	now injury	y occurred			
2	Atter r deat ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b	e 28e. Place	of injury - /	At home, fa	rm, stre	et, factory, office		28f. Location (or Rural	Route Numb	oer,
5	s afte	Certification:	4 Homicide		Duligin	g, etc. (Sp	еспу)				City or To	vn, State,)			
ĺ	I of the flospital or Attending Prysician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only	XCertifying P 2☐ Medical Exa	hysician: To the I	best of my	knowledge	e, death	occurred at the ti	me, date and place	, and due to the	cause(s)	and mann	er as st	ated.	
	the P hin 24 the F mplet	Medical	one)	0	and mann	er stated.			29c. Licens							
ı	0 wit		29b. Signature and	title of certifier		000	9-0			D59142			e signed <i>(l</i> uary		-	,
	10		30 Name of L	le	completed a	of doct	(Itom 22=) (Type 5	Print\							
			30. Name and addr	ress of person who Boice,	M.D. 10					#205, Sil	ver Spr	ing,	MD 2	090:	2	
175	Sta	ite	31. Date filed (Mon		32	gistrar's S	ignature	0								
	Registr	ar	JP	N 11 2	JU1 /	eve	K	April	W							

			For State Registrar	State	of Marylar		irtment of t		nd Mental Hy	giene Reg. No.	7 02112)
7	Physici	an	1. Decedent's Name (First, Midd						2. Date of De		3. Time of Death	
	/Medic	cal	FRANCES LOUIS 4a. Facility Name (If not institution		umber)		4b. City, Town, o	or Location of		4c. County o		М
÷	(A)		CHESTERTOWN N					ERTOWN		KENT		
	uneral irector		5. Social Security Number 219-14-2394	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 9:		Months Days	If Under 24 Hours	Min. 8. Date of Bir 01/15/1	1913	Birthplace (State or Forei Country) MD	ign
land	Mo m		Usual Residence of Decedent 10a. State 10b. County	/	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limi	its
е Мал	Ba-f eh	ctor	MD KEN	T	RO	OCK HAL	.L				1 □ Yes 2\\□ N	10
with th	3a or 2	i Dire	10e. Street and Number 21007 BAYSIDE	AVE.			10f. Zip Code 2166	1		10g. Citizen of Wi	hat Country?	
:1215-0036 within 72 hours after deeth with the Maryland	or hybers of other than "naturel", or items 23s or 28s-f show event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	ried 1 ☐ Yes	2 🛣 No iive	11	Vas Decedent of I Yes, specify Cub	an, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		- American Indian, , White, etc. WHITE	
215-0036 Ithin 72 hours af	natur	ieted	(Specify only highe	nt's Education est grade completed)	(Give	ent's Usual Occup kind of work done OO NOT use retire	during most o	of working	16b. Kind of Bus	iness/Industry	
N DE	the M	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	HOMEM		a)		OWN HOM	E	
ld be filed		To Be (17. Father's Name (First, Middle, GEORGE THOMAS	,					A. MOORE	, Maiden Sumame)	
Maryland d 2 should be file	t nealth and Mel	-	19a. Informant's Name/Relations KAY GLENN/DAU						or Rural Route Numb HAVRE DE G			
G Lan	f Item 2 r other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation		_	Place of Dispos	sition (Name of	ce)	Date	20c. Location - C	City or Town, State	
altimore,	Important: If It		4 □ Donation 5 □ Other (S	Specify)	W	-	HAPEL CE	_	01/15/20	7 ROCK	HALL, MD	
e e	imp eny eny		> Luck of.	Helfen	bein	FE 13	LLOWS H O SPEÈR	ELFENB ROAD,			ERAL HOME, PA	A
	/sician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that t only one cause on a	each ling.		or the mode of dying	7 0		rrest,	Approximate Interval Between Onse and Death	
	ledical aminer			Due to	(or as a conseq	uence of):						
ted	nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):						
cate be executed	physicien and the burial-transit	i Examin	that initiated events resulting in death) Last	C. Due to	(or as a conseq	uence of):						
	g physic as the b	edicai		d								
O. BOX the	by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live	utcome of pregna birth 2 Peta mant at time of d nown	Ideath 3 🗌	Ectopic pregnanc Other (specify)	/		23d. Date Mont		
ords, P.O	should be deta	þ	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the un	derlying cause giv	en in Part I.	23e. Did t		oute to the cause of death?	vn
<u>a</u> a		ompieted							24a. Was	osy 🌶 pri	ere autopsy findings availab or to completion of cause of	ole f
_ =	pag.	e Con	25. Was case referred to Medica					00 Bloom	perfo	rmed? de 22 No 1E	ath? ☐ Yes 2☐No	
OT VITA Physician:	(O) (O)	To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	3□ DOA Ott	100	Death (Check only only only only only only only only		(Specify)	
G # -	After	tion:	27. Manner Death 1 Natural 5 Pendir 2 Accident investi	28a. Date (Moi igation	of Injury oth, Day Year)	28b. Time of Injury	28c. Injui Wor M 1 🗆	yat k? Yes 2 ∐No		how injury occurred	d	
DIVISION al or Attending s after death.	Funeral Director: (ely filled in by the	Certification:	3 Suicide 6 Could determ	nined 289. Plac	e of Injury - At ho ding, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (S City or Tox		or Rural Route Number,	
Hospital	E SE	Medical (29a. Certifier 1 Certifyii (Check only one) 1 Medical	Exeminer: On the i	e best of my kno basis of examina oner stated.	wledge, death tion and/or inv	occurred at the till estigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)	
To the	To the complete	Me	29b. Signature and title of certifie	Ch	`		29c. Licens	e number	54	29d. Pate signed ((Month, Day, Year)	
	,		30. Name and address of person	who completed cau	ise of death (Item	23a) (Type, F	Print)	760-	7	11161	<u> </u>	
9996	בריו		31. Date filed (Month, Day, Year)	>1979WE	Registrar's Signa	DID IZO	Speerk	D Bld	3B Chest	textown	MD 21628	_)
	Sta Registr	_		2 2007	Kenn .	No a	C. W.					

				For State Registrar		State of r	viarylan	-	artmer <i>rtifica</i> t		ealth and i Death	Mental Hy	/gien Reg. Ne	ZUL	7	02113
		Physici	an	Decedent's Name (First,	Middle, Las	t)	****					2. Date of D Month			Y <i>e</i> ar	3. Time of Death
4		/Media	cal	John Russell					T			Jan	22	20	07	09:30 M
		Examir	ner	4a. Facility Name (If not ins Harford Memo							Location of Death	h		c. County o Harko		
		Funeral		5. Social Security Number	6. Se	9x 7.		last birthday)	If Unde	r 1 Year	If Under 24 Hrs.	8. Date of B	irth			ace (State or Foreign try)
		Director		516-20-6856		□M 2□F		33 Yrs.	Months	Days	Hours Min.	Sept.	1, Year	923	Mont	iana
		land ow		Usual Residence of Deceder 10a. State 10b. C			10c. Cit	y, Town or Lo	ocation						10	Od. Inside City Limits
		with the Marylan a or 28a-t ehow	tor	MD Ha	urford		Hav	ire de	Grac	e.						1 ☐ Yes 2 ☐ No
		ith the	Director	10e. Street and Number					10f. Zij	Code			10g. C	itizen of Wi	hat Coun	try?
		ath w	ral	943 Nena Ave	enue					078				S.A		
	40	ter de	Funeral	11. Marital Status 1 □ Never Married 2 □	Married	12. Was Decede Armed Force 1 X Yes 2 [s?	.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race Black	- America , White, e	
	936	ours aft	Ď	3 ☐ Widowed 4 ☐ Div		If Yes, Give Year or Date:	_	60	1 □ Y <i>e</i> s	2 🗖 No	Specify:			Specify:	Whi	te
	5-0	72 ho	etec	15. Dec (Specify only	cedent's Edi	ucation de completed)		16a. Dece	kind of wo	rk done d	luring most of wor	rking	16b. k	Kind of Bus	iness/Ind	ustry
	21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or Items 23e or 28e-t ehow event, It a Mcdical Examinar must be notified at	Completed	Elementary/Secondary (0	-12)	College (1-4c	or 5+)		DO NOTU S. Ar)		G	overn	mout	
		e filed within the Hygiene.	Be Co	17. Father's Name (First, M	iddle, Last)	्प		u	3. FVL	1.119	18. Mother's Nan	ne (First, Middle	<u> </u>			,
2	/lar	2 should be and Mental le marked of aumatic eve	To B	Fred Kapinos)						Margar	et Kapi	nos			
am	Maryland	12 shc and raum raum		19a. Informant's Name/Rela		ype, Print)		1			and Number or Ru					
-		s 1 end 2 should be filed f Heelth and Mental Hyg ftam 27 le marked othe other traumatic event,		Geraldine Ka	ipinos		20b. P	lace of Disoc	sition (Na.	me of	ue Havre	de Gra		MOTYX -ocation - C		
930	ē	Pages ment of I tant: If its jury or o		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ott			te C	emetery, crei	matory or c	other place	110	3/2007	file t	+ Cha	. + 0 4	DΛ
00	Baltimore,	permit. Pages Department of I Important: If its any Injury or o		21. Signature of Suneral Se		22	- 10.7	22 M.	2. Name ai	nd Addres	s of Facility 1	23 S. W	ashi	ngton	St.	, IA
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-		Dhysisian		shock, or heart failure Immediate Cause (Final	List only o	ine cause on each	line.		or the mod	-1						Approximate Interval Between Onset and Death
_		Physician /Medical		disease or condition resulting in death)	-	a. Due to (or a	as a conseq	uence of):	7	1 1 10	bracic	7 0	14	•	7	WKS
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10	D.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last		Due to (or a	as a conseq	uence of):								
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		ertifica ding ph	/Med	IF FEMALE:	- 1	22. 1							-		1	
-	Box	attend for us	clan	23b. Was decedent pregna in the past 12 months?	III.	23c. If yes, outcom 1□Live birth 4□Pregnant	2 Feta	death 3	Ectopic p					23d. Date Monti		y Day Year
7	0.	it the d by the tached	by Physician/M	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknown										
7	S,	Attanding Physicien: The law requires that the death cert death. ector: Atter this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	by P	Part II. Other significant co	nditions co	ntributing to death	but not resi	ulting in the u	nderlying o	ause give	n in Part I.			_		e cause of death?
10	Vital Records,	v requir been s should	Completed													bly 4 🗍 Unknown
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\sim	Ital	ician: The la certificete has rector, page 2	Be Co	25. Was case referred to me	edical						26. Place of Dea	1 □ Y <i>e</i> s	2 N		Yes 2	2□ No
=	of V	nysici nis cer direc	10 B	examiner? 1 ☐ Yes 2 No	Ī	Hospital: 1 🗌 Inpa	tient 2	ER/Outpatien	t 3 D		r: 4 🗆 Nursing H			6 □Other	(Specify)	
		ing Pt After th uneral	Ë	27. Manner of Death 1 ☑Natural 5 ☐ P	ending	28a. Date of In (Month, I	njury Day Year)	28b. Time of Injury		28c. Injury Work	at ?	28d. Describe				
7	Division	death ctor: / y the f	Icat	3 ☐ Suicide 6 ☐ C	ould not be	28e. Place of I	niury - At ho	me form etc	M		'es 2 □ No	28f Location	Street ar	nd Number	or Pural	Route Number.
	D	s after bl Dire	Certification;	4 ☐ Homicide a	etermined	building,	etc. (Specify)	out, ractor	y, onice		City or To			Or Hurar	riodie ridriber,
		To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	cal	(Chack only 21 I Mai	dical Evami	sician: To the be-	of ovaminat	ion and/or in	coctionstine		inion donth annu	read at the time	dese ee.	d al = = = = =	and and come as a second	No. of the Control of
		To the within To the comple	Me	29b. Signature and title of co	ertifier	and manner	stateu.		290	. License	number		29d. Da	ite signed (Month, D	ay, Year)
				> lwh	ran	_ M	1)			D	32600	7	1/2	2310	7	
		12		29b. Signature and title of control of the control	rson who co	ompleted cause of	death (Item	23а) (Туре,	Print)		Ha.	. (~		m =	1187	C
		Sta	te	31. Date filed (Month, Day	Year)	2. Regis	strar's Signa	ture	1617	2	wre	الع الع				.
		Registr	ar	JAN 2	b ZUU	File 18	15.	600	A second							

			1 - For Stete Registrar	State of Ma		d / Depa	artmer	nt of H		and N	Mental Hy		e 0	07	02114
			Decedent's Name (First, Middle, La	st)							2. Date of D			.,	3. Time of Death
3	Physici		Harvey David Mile	s Knioht							Month J And U	Ada	ay g	Year	120 AM
×	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City	, Town, or	Location	of Death			c. County	y of Death	
*	LAGITINI	C	Anne Arundel Medi	ical Center	r		Ann	apo1:	is			A	nne	Aruno	iel
	Funeral		5. Social Security Number 6. S	Sex 7. Age		ast birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth	r)	9. Birth	place (State or Foreign
S.	Director		578-26-0847	ŽMM 2□F	83	Yrs.	Months	Days	Hours	IVIIII.	04/29/	1923	3′	Wash:	ington, DC
Т	D		Usual Residence of Decedent 10a. State 10b. County		100 City	, Town or Lo	antion.								10d. Inside City Limits
	anyla ehov	-													1X Yes 2 □ No
	Ba-f	Director	PA York		New	Cumber						10- 0	Distance of	What Cou	ntn/2
	with t		10e. Street and Number					p Code						What Cou	ntry:
	s 23	Funerai	707 Myrtle Court	12. Was Decedent	Ever in 11.9	S 13	170		spanic Or	igin? (Sr	acifu Yas or N	US		ce - Ameri	can Indian,
	item item	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		3.	If Yes, spe	cify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)			ck, White,	
36	l', or	by F	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:		49	1 ☐ Yes	2 X №	Specify:	:			Specif	^{fy:} Whi	te
ð	be filed within 72 hours after death with the Maryland is Hygiene. Hygiene dit Hygiene other than "naturel", or items 23s or 28s-f show event, V.a. Medical Evarial artificial at avent, V.a. Medical Evarial artificial at	ted	15. Decedent's E	ducation		16a, Dece	dent's Usu	al Occupa	ation			16b.	Kind of B	lusiness/ir	
215	hin 7.	ple	(Specify only highest gra	de completed) Coltege (1-4or 5	(+)	life.	DO NOT	use retired	furing mos ')	st or won	ang				
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g	al Hy	Be (17. Father's Name (First, Middle, Last,)							e (First, Middl			•	
<u>a</u>	Ments Ments arked	To	Bland Massey Knig	ght					Cath	eri	ne Grac	e Th	ornt	on	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene and Inducely, or tiems 23a or 28a-f show morp injury or other traumatic event, I'm Medical Examinating Iranial terminities at Once.		19a. Informant's Name/Relationship (Type, Print)							al Route Num.				
≥ ,	and ealth n 27 ner tr		Ron Knight/ Son		1	-			urt N		Cumber1				
Baltimore,	of H of H if item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. PI	lace of Dispo emetery, crei Mary	natory or	me of other place	θ)		Date	20c.	Location	- City or T	own, State
Ē	Pag ment ent: lury c		4 ☐ Donation 5 ☐ Other (Specif		Vet	erans	Ceme	etery			2/2007			nham,	
Sall	Depart Depart Import eny in		21. Signature of Funeral Service Lice	asee											al Home
_	40 E 3 G		FULL								ad Bowi		MD 20)715	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lir	the death ne.	. Do not ent	er the mo	de of dying	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
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1	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):									
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	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due 10 (01 as	a consequ	161106 01).									
	le be executed ysicien and e burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of):							-		
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687	ficate physics the			d											
	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7= .						23d. Da	ate of deliv	ery
. Box	death a atte d for	cla	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant at			Dectopic postport	pecify)					Mo	onth	Day Year
Ö.	t the by the ache	hys	9 □Unknown	9□ Unknown											
ري. ص	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the u	nderlying	cause give	en in Part I	l.	23e. Did	tobacco	use con	tribute to t	he cause of death?
Records,	w require been sig should b								· ·	-	1	Yes	2 🗆 No	3 Pro	bebly 4 Unknown
ပ္က	aw re is bet 2 sho	Completed									24a. Wa	s an			opsy findings available
	The lav	E										formed?	·	death?	
Vital	ysician: The is certificate hadirector, page	0	25. Was case referred to medical						26. Place	e of Dear	th (Check only				
	Physical this cerral direct	To B	exa <i>m</i> iner? 1 ☐ Yes 2 / No	Hospital: 1 Hnpatie	nt 2 🗆 E	ER/Outpatier	nt 3 D	OA Othe	er: 4 □ Nu	ursing H	ome 5⊟Res	sidence	6 □Oth	her (Specia	(y)
0	Attending Physician: Ir death. •cfor: After this certifici by the funeral director.		27. Manner of Death 1 ⊠Naturat 5 □ Pending	28a. Date of Inju (Month, Da)	ry y Year)	28b. Time o Injury	f '	28c. Injury Work	at c?		28d Describe	how in	jury occur	rred	
Ö	ittendir death. ctor: Af y the fu	atic	2 ☐ Accident investigatio	t			M	10	Yes 2□	No					
Division of		Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju-			eet, facto	ry, office			28f. Location City or To	(Street a	and Numi ite)	ber or Run	al Route Number,
	rel D														
	To the Hospitel or within 24 hours afte to the Funerel Dir completely filled in	edicai	29a. Certifier Check only 2 Medical Exer	nysician: To the best niner: On the basis of	examinat	wledge, deat ion and/or in	h occurred vestigation	dat the time n, in my op	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	e cause e, date a	(s) and <i>m</i> nd place,	anner as s and due t	stated. o the cause(s)
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l .	N N N		14-6												•
				, M.D.		00-1 7		2005	665	8		57.	and it	48,	rust
	ini		30. Name and address of person who				Print) PARKL	WAY	Ada	APOL 15	me	21401			
	Sta	to	31. Date filed (Month, Day, Year)	32 registra			MINNE		N-Hat A	70015	17.7	-401			
	Registr			2007		N A	mark	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryand Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3 Time of Death Month **Physician** Year HWAN 0510KM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMONE 5. Social Security Number 00 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country)
S KOREA 1 **3** M 2 □ F 212 51-Director 54 1952 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD ANNE ARUNDEL GLEN BURNIE 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 21060 300 DARK STAR WAY USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ASIAN 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the PROPRIETOR DRY CLEANING marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill.
Health and Mental H
tem 27 is marked oth Be CHAE KEUN LEE NAK MAN SUNG ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, YOUNG J00 LEE /WIFE 300 DARK STAR WAY GLEN BURNIE MD 21060 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Purial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) CREST LAWN MEM. GDNS 1/9/7 MARRIOTTSVILLE MD 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 21. Signature of Ineral Ser 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HEMORRITAGIC SHOCK /Medical Due to (or as a consequence of): Examiner COAQUIOPATITY Sequentially list conditions Examiner cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed CIRRHUSIS burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) the 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No certificate 1□ Yes Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435M 16540

State Registrar

MUDD GREENE STREET 22 ANNA 31. Date filed (Month, Day, Yea JAN 1 1 2007 32. Registrar's Signatu

address of person who completed cause of death (Item 23a) (Type, Print)

S.

BATIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician John A1an Logan 2007 06, January 3:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Arcola Health and Rehab Center Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 X M 2 □ F 216-40-8043 Director 63 Dec. 26, 1943 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 United States 901 Arcola Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No 1962 If Yes, Give Year or Dates: 1963 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify. þ Specify: 3 Widowed 4 Divorced 1963 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Estimator Building /Construction permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, <u>I</u>II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pauline Mildred Bortree Melvin Harvey Logan Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Buckler / Spouse 2477 Showbarn Circle, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 1/12/2007 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Inter the disease, recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Lift only one cause on each line.

Immediate lause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Metastatic Brain cancer Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Lung cancer Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

physician and s the burial-tran that the death certificate be execu P.O. Box 68760. Records, Division or Vital Hospital or Attending

show

'natural", or

Baltimore, Maryland 21215-0036

within 24 hours a

To the Funeral L

Nasreem Mustafa Kango, M.D. 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carroll Avenue #205, Takoma Park MD20912 egistrar's Signature

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Registrar

DHMH 17 Rev 1/2001

07-00106 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gorman Lankford, Sr Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death January 4, 2007 1605 hrs Medical Examiner Myles Gorman Lankford 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Cambridge Dorchester Dorchester General Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Min Director Country) Maryland 220-32-7845 1 XM 2 F 70 June 22. 1936 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Yes 2 X No Dorchester MD Cambridge Director 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 2035 Church Creek Road 21613 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes f Yes. Give Year white 3 X Widowed 4 Divorced 1 Yes 2 X No specify: Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Pages I and 2 should be filed within 72 I: tent of Health and Mental Hygiene. ant: If item 27 is marked other than "n Flementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 mechanic automotive 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin M. Lankford Helen Marshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gorman M. Lankford, 608 Diamond St., Easton, MD son 21601 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 1/9/07 Cambridge, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St Cambridge. MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Day Fetal death past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? Yes 2 V N After this certificate 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day,Yaar 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 V Natural Yes 2 No Director: d in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral D

> 31. Date filed (Month, State

DHMH 17 Rev 1/2001

OCME 2006

29)

Signature and title of certifie

Laron Locke MD.

and manner stated.

Assistant Medical Examiner

Name and address of person who completed cause of death (Item 23a)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 5, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Jean Lint January 10, 2007 12:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge
If Under 1 Year | If Under 24 Hrs. Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔏 F Days Hours 170-30-2509 76 Director March 25,1930 Japan Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itame 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Itame 23a or 28a-1 show any injury or other treumatic event, the Medical Examinating must be notified at 1XYes 2 No Dorchester Funeral Director Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Glenburn Ave. **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3₺Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Oak Cove Road, Titusville, FL. 32780 Dennis L. Lint 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/10/07 Salisbury MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 22. Name and Address of Facility Thomas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 700 Locust Street, Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ayteriosclerohe Heart Immediate Cause (Final Discore Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the attending physicien and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Demeuna 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 72KG I Director: After this id in by the funeral d After this 27. Manne Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier t 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47924 1-10-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 AURORA CAMBRIDGE MD 2/6/3 NOMAN THANWY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2007 Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 2 2007

29b. Signature and title of certifier



's narra ha

30. Name and eddress of person who completed cause of death (Item 234) (Type, Print)

29c. License number

D60826

29d. Date signed (Month, Day, Year)

January 8, 2007

Silver Spring, Maryland, 20910

			For Stete Registrar	State of Marylan		tment of Hea ificate of De		ental Hygien Reg. N	21111/	02121
	Physicia	an	Decedent's Name (First, Middle, Last)	1	me	101			ay Year	3. Time of Death
	/Medic	al	Pallo Mr 4a. Facility Name (If not institution, give(s		0	4b. City, Town, or Los		Jan 11	2007	
	Examin	er	2446	on 5+		5, lver	Sprin		nontes	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.			Under 24 Hrs. Jours Min.	Date of Birth	9. Birth	nplace (State or Foreign untry)
	Director		None	^{M 2□F} 76	Yrs.			03/25/19	930 E1	Salvador
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
	Mary	tor	Md Montgo	merv Si	lver	Spring				1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	untry?
	e 23e		2404 Sheraton	Street 2. Was Decedent Ever in U.	C 12 W	20906 as Decedent of Hispa	onia Origin? (Sono	E :	Salva	
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21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23e or 28a-f ehow he Madical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	XYes 2□No S	Specify: E1 S	alvador	Specify: H	ispanic
5-0	72 hours "naturel", adical Exa	Completed	15. Decedent's Educ (Specify only highest grade		(Give k	int's Usual Occupation ind of work done during O NOT use retired)	n ng most of working		Kind of Business/	Industry
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	othe	BeC	17. Father's Name (First, Middle, Last)				. Mother's Name	First, Middle, Maide		
Maryland		Tof	Jose Mejia					Lozano		
Mar	id 2 sho lith and I 27 ie ma		19a. Informant's Name/Relationship (Type: Lucila Lozano/N			Address (Street and Sherator				
	Hea The		20a. Method of Disposition	20b. P	lace of Dispos		Da	The second secon	Location - City or	
D E	Pages nent of ant: if it		1 Surial 2 Cremation 3 Real A Donation 5 Other (Specify)	moval from State		Cemeter	y 01/2	1/07 El	L Salva	dor
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License		22.	Name and Address of	of Facility Mur	ray Fune		me 4804
_	#Q = ₽ 9		Phillip D	ella		eorgia A			20011	Approximate
			23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final	e cause on each line.	n. Do not ente	r the mode of dying, s	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	V /					mE
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	and al-trans	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal E								
9	rtificat ng phy s as th	Medi	IF FEMALE:	1888					1	
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of details.	il death 3 □1	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
P.O.	that the de ed by the a detached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	eath 5∐	Other (specify)				
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ords	w require been sig should b	ted t						1 Tes	2-0 No 3 □ Pr	obably 4 Unknown
Vital Records,	e law r has be je 2 sh	Completed						24a. Was an autopsy	24b. Were au prior to death?	topsy findings available completion of cause of
al								performed? 1 ☐ Yes 2 ☐ V		2 □ No
VII.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 XYes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	Other	6. Place of Death 4 □ Nursing Hom	(Check only one) e 5 Residence	6 □Other /Spe	cify)
J of	g Phys ter this neral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how in		,,
sior	Attending or death.	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 ☐ Yes	s 2 □No			
Division	after d after d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	ome, farm, stre (y)	et, factory, office	2	Bf. Location (Street and City or Town, Sta		urai Houte Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a Cartifer 1 ☐ Certifying Phys	ician: To the best of my kno	disst. ephelwo	conumed at the time	date and plane, ar	nd due to the cause	4) and manyor as	stated
	in 24 I in 24 I ihe Fu ipletely	edical	one)	er: On the basis of examina and manner stated.	ation and/or inv					
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	· Wirm	1.00	29c. License n		1 .	Date signed (Mont	•
2			30. Name and address of person who co) ME		428	N D.11	E 11.	200/
K	(2)		IRA No. BRE	CKER, MC		Silve	0 / 50 V	1-2 m	17 20	902
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	,	J			
	Regist	rar	JAN 1 2 2007	March D.	worker	-				

Physician
/Medical
Examiner

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Md. 23957 Funeral Maryland 21215-0036 þ Completed Be (Baltimore, Physician /Medical Examiner Examiner law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: ρ signed to Completed by page 2 should Physician: funeral director. Be Certification: To this Hospital or Attending death. 24 hours after death Funeral Director: filled in by the 29a. Certifier (Check only one) the MOSI State JAN 1 2 2007 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 8:05 PM January 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death Mospita Johns Mopkins If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1**⋉**M 2□F 81 Iran 374-36-2813 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Talbot 1 TYes 2 XNo Bozman 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Vandenburg Ln. 21612 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 Yes 2X No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pediatrician 5+medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mohammed Mehrizi Nosrat Mehrizi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21601 David Mehrizi / son 6543 Peach Blossom HeightsDr., Easton, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State Parklawn Cemetery 1/11/07 Rockville, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Servin Licensee 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxia Due to (or as a consequence of): Biliamn Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 □ Yes 1∐ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe St. Baltimore Margiane

Bennett 31. Date filed (Month, Day, Year,

600 North 32. Registrar's Signatu

07-00167 Ric

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ricardo Mitchell	- F	- For State Registrar		of Maryland /		ment of <i>icate of</i>		d Mental F		eg. No. 200	7 0212:
Physician Medical Examin	7	1. Decedent's Nam RICAR	e (First, Middle,Last)	MITCHELI	, II				2. Date of Deat Month January 6.	Day Year	3. Time of Death 1356 hrs
		4a. Facility Name (if not institution, give	street and number)		4	b. City, Town, or Baltimore	Location of Deat		4c. County of Deat	h
Funeral Director		5. Social Security N			(In yrs last)		If Under 1 Yea			th(MM/DD/YYYY) 9. Bi	gn
	E	Usual Residence o		M 2 F		3 Yrs			APRIL	14 1983 Forei	ountry) MD .
Ow any	1	10a. State	10b. County P.G.	1	•	wn or Location			-		10d Inside City Limits 1 X Yes 2 No
faryland	Director	10e. Street and Nu			н	YATTS	10f. Zip Code		11	Og Citizen of What Cou	
th the Maryland 23a or 28a-f show notified at once.			MILTON N	MANOR DRI				782		USA	
er death w	by Funeral	11. Marital Status1 X Never Marri3 Widowed		12. Was Decedent E Armed Forces? 1 Yes 2 2	No No	If Ye		n, Mexican, Puert	Specify Yes or No o Rican, etc.)	14. Race - Amer White, etc. BLACK Specify:	ican Indian, Black,
hours a		15 Decedent's Edementary/Second		y highest grade comp College (1-4 or 5+				tion (Give kind of a. DO NOT use re		16b. Kind of Business	Industry
5-0036 led within 72 Hygiene. other than	Completed	1 2		College (1-4 of 54	, I	CUS	STODIAN	I		PVT.	
215-0 be filed v mtal Hygi rked oth	် ရ	17. Father's Name RICAR	(First, Middle, Last) RDO MI	CHELL					ADAMS	Maiden Surname)	
MD 21 and 2 should 1 alth and Mer m 27 is man auturatic ev] ≏		ame/Relationship (Ty DAMS/MO			5618	HAMILI	ON MAN		ber, City or Town, State 5 HYATTS	
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra				Removal from State			tion (Name of ce		13/07	20c Location - City of LANDOVER	
Baltil permit. I Departm Importa			uneral Service Licens	ee	1		ame and Addres		35 l4th	ST., N.V	20010 V.WASH.DC
Physician /Medical		23a Part Enter the failure, List or	he disease, or compl nly one cause on eac	cations that caused the	ne death. Do						Approximate Interval Between Onset and
Examiner	1	Immediate Cause or condition resulti	_	Complications of Oue to (or as a consec		uries					Death
	ا ا	Sequentially list co		Oue to (or as a consec	uence of):						
	Examiner	cause. Enter Under Under (Disease of injury) events resulting in	triat irritiated C _	Due to (or as a consec	uence of):				574		
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60, ate be e: hysiciar e burial	Medical	UNPENDED		AMENDED 23c. If yes, outcome	e of pregnan	ncy			-	23d. Date of deliver	v
c 6876(certificate anding physuse as the b	cian/l	23b. Was decedent past 12 month:		1 Live birth 4 Pregnant at ti		2 Fe	tal death 3	Ectopic pregr	nancy	1	Day Year
O. Box 6876 that the death certificat ned by the attending ph detached for use as the	Physician/I		No 9 Unknown	9 Unknown contributing to death				niver in Death	22a D.d.		
8 .go e	ݳ	7 art ii. Ottier sign	inicant conditions	contributing to death	but not resu	iting in the c	inderlying cause	given in Part I		bbacco use contribute to	
of Vital Records, ag Physician: The law requir Mer this certificate has been 5 meral director, page 2 should	Completed								24a Was autop	sy prior to	utopsy findings available completion of cause of
	E C								1 🗸 Yes	rmed? death? 2 No 1 Y	es 2 No
Vital ysician: his certi	e Be	25. Was case reference examiner? 1 ✓ Yes		ospital: 1 V Inpatien	t 2 EF	R/Outpatient		e of Death (Check Other: Nurs		Residence 6 Othe	er:
C := _ ^ =	on:	27. Manner of Dea	5 Pending	28a. Date of Injury (Month, Day Yea Dec 30, 2006		3b. Time of I 308 hrs		ury at Work? Yes 2 ✓ No		how injury occurred auto-fixed object o	collision
Division Hospital or Attendio 24 hours after death Finneral Director: A	Certification:	2 Accident 3 Suicide	Investigation 6 Could not t	28e Place of Init	iry - At home	e, farm, stree			28f. Location (Street and Number or R	ural Route Number, City
Divis ospital or At hours after d uneral Direc		4 Homicide 29a. Certifier	determined	1 (opening) Iviajo						state) t. 175, Jessup,	
To the Hos within 24 h To the Fun	Medical	(Check only one) 2								se(s) and manner as sta and place, and due to the	
F # F 5	ž	29b Signature and	d title of certifier	9 0000		·	29c. Licen	se number		29d. Date signed (Mo	
	}	30. Name and add	dress of person who	completed cause of de	ath (Item 23	Ba)	0.0	.IVI. L .		January 7, 2007	-
CR (6)		Carol Allan	, MD Assista	nt Medical Exam	iner 1	11 Penn S	Street, Baltim	nore, MD 212	01		
Sta Registi	ite ar	31 Date filed (Mor	1 1 2007	32. Registrar	s signature	ock	,				

DHMH 17 Rev 1/2001

WAYNE

MURPHY,

PHYSICIAN:

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KNOWN

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #5, perFH, g864, 2/21/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Year **Physician** SUM George Ronald Moore January 8, 2007 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Thomas More Nursing & Rehab. Center Hyattsville Prince George's 5 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 56 Director 577-68-4269 10/3/50 Wash., D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "netural" -- " any fijury or other traumatic event." 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No **Funeral Director** D.C. Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4245 Massachusetts Ave., S.E. 20019 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 175-19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 75-195 Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 45€ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Specialist Private Industry 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl S. Moore Bessie Patterson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Harold L. Moore/Brother 4245 Massachusetts Ave., S.E., Wash., D.C. 20019 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 1/19/07 Ft. Myer, Va. 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee JA W any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final · Artenioscherotic Candiovascopi Disease disease or condition resulting in death) **Examiner** Examiner or Attending Physicien: The law requires that the death certificete be executed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ finknown Cenebral Thuombosis Completed by 24b. Were eutopsy findings availeble prior to completion of cause of death? 24a. Wes an autopsy performed? Seizone Disorder Diabetes Mellitys Hypertension 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide To the Hospital of within 24 hours a To the Funeral D 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

29c. License number

29d. Date signed (Month, Dev. Year)

State

203 Oversbury Rd Hygttsville MD 20181 32. Registrar's Signeture 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Year 9, 6:57pm 2007 January Christopher Jan Michejda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** 1 X M 2 □ F Director 335-30-1105 69 Dec. 19, 1937 Poland Poland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director North Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event the last statement of the last statement. 20878 Funeral 13814 Hidden Glen Lane United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2X Married 1 ☐ Yes 2 ☒ No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Senior Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Jan Michejda Janina Trybulski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Michejda (Spouse) 13814 Hidden Glen Lane, N. Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 1/10/07 Alexandria, Virginia 21. Signature of Funeral Service Lic 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 rdisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No autopsy perform 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA s after dea... Certification: To

Physician /Medical Examiner

and

or Attending Physician: The law requires that the death certificate be executed

certificate

this

To the Hospital o within 24 hours aft To the Funeral DI

Division or Vital Records, P.O. Box 68760,

with the Maryland

3altimore, Maryland 21215-0036

1 ☐ Yes 2 No 27. Manner of Death 5 Pending investigation 1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title

6 Could not be

determined

29c. License number

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Dav. Year) January 10, 2007

ss of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury

(Month, Day

8600 Old Georgetown Road, Bethesda, MD 20814 Rothstein MD Robert

28b. Time of

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 11 2007 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3:45 A JAN. 10, 2007 Μ. McQUEARY JOHN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BURTONSVILLE HOLY CROSS REHAB. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 1**X**M 2□ F Months MARYLAND 579-48-2090 72 JULY 4, 1934 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Director **GAITHERSBURG** MONTGOMERY MD. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 U.S.A. 9 CHESTNUT ST. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CREDIT SERVICES SALESMAN 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DENNIS **EVERETT McQUEARY** LUCIA REBECCA MAXWELL ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 810 GASCON PL., TAMPA, FL. 33617 ADAIR/COUSIN PATRICIA M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
importent: if ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) * 4 Donation CHAMBERS CREMATORY 1-11-2007 RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. /Chamberson M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician uracmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown is been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hy pertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4. Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 (No Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours efter death To the Funerei Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Day, Year) 31. Date filed (Month, 2007 DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 117

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	Funeral Director		5. Social Security N 097-03-0876 Usual Residence of		6. Sex 1 ∏	M 2□ F	7. Age	(in yrs. i	ast birthday 3 Yrs.	Mont			Min.	8. Date of E (Month, I APRIL			9. Birthp Coun NEW Y(ate or Foreig	n
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<u>g</u>	parmit. Par Dapartmen Important: any injury once.		21. Signature of Fu	neral Service I	Licensee	, n						ess of Facili		OME, INC						
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	/Medical Examiner		Immediate Cause disease or condition resulting in death)	n	a.	CONGES	STIVE	HEAR	T_FAIL	JRE								L WEE	CK	
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1 3	>		30. Name and addr	ess of person v	who com	pleted cau	se of dea	th (Item	23a) (Type						J.1111	· · · · · · · · · · · · · · · · · · ·	2007			
			JAMES A. R	OSSI, M.I)., 3					LVD.,	SILVE	R SPRI	NG, M	ARYLAND	2090	06				
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State of Maryland / Department of Health and Mental Hygien® For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year рМ Frank Laurence Macri 2007 January 6, 2:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1⊠M 2□F Yrs. Director 213-48-3859 53 Dec. 14, 1953 Maine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3602 Janet Road 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) other then 2 County Schools Building Services Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi h and Mental F Frank John Macri Lois Ann Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 ment of Heelth a ent: if item 27 is ury or other trea Anne L McHenry/ Sister 8003 Piney Branch Road, Silver Spring, MD 20910 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12, Silver Spring, Maryland ertment ortent: if Gate of Heaven Cemetery Jan. 4 ☐ Donation 5 ☐ Other (Specify) 2007 permit. Departr Import any inju 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 amos 23a. Part1. En ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL Physician FARCTION MINUTES /Medical Due to (or as a consequence of): Examiner THEROSCLEPOTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physiclen end the burial-transit The law requires that the death certifica a be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the the ettending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Division of Vital Records. à page 2 should be 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificete 1 Yes 2 No 25. Was care referred to medical examiner? funeral director, Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Z ER/Outpatient Certification: To 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 atural 5 Pending death. М 1 TYes 2 TNo 2 Accident investigation To the Hospital or Attent within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE PHILIP DR. , M.D. HERRING 18101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 11 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 1 | 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** REGINALD JANUARY 10, 2007 WARREN 12:39P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2□ F Months Days Hours Min. Director 215-68-9297 09-28-57 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11036 Pleasant Walk Road 21773 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2No Specify Specify: 3 ☐ Widowed 4 🗓 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I es 1 and 2 should b of Health and Ments Paul Warren May ျ Wanda Lee Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15863 Strooptown Road Timberville, VA 22853 Paul Warren May, father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Grove Cemetery 1/14/07 Fulks Run, Virginia 22 Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part. Enter the Isease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cormony discose artery /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as the attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 1∐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending To the Function after death.

To the Funeral Director: After the function of t investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10054261 1/10/07

Registrar

State

Goarles

Frederich MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCOTT NOWLIN MI) 400 w. 7# st.

32. Egistrar's Signature

31. Date filed (Month, Day, Year) 2 2007

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f Item		20a. Method of Disposition			1 0	lace of Dispo	osition (Nan	me of other plac	e)	D	ate	20c. L	ocation - City	or Town, State
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Thomas Ear1 Marsellas, Sr. 2007 January 7 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Nursing and Rehab. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 212-36-8266 Director Jan 19 1939 Maryland 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at Director 1 ☐ Yes 2 No Anne Arundel MD Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1758 Dunton Road 21401 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 N Yes 2 No If Aes, Give Year or Dates: 1956-57 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White Completed by 3 ☐ Widowed 4 🔀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Well Driller mechanical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be James Melvin Marsellas Sr. Louise Parker ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other trat Emily Wallace (sister) 1758 Dunton Rd Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Jan 11, 2007 Annapolis, MD Hillcrest Cemetery 4 Donation 5 Dother (Specify) 21. Signatu of Funeral Service/Icensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A 12 Ridgelv Avenue, Annapolis, MD 21401 23a. Part1. shock nter the di ease, or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death tercause (Final condition in death) ediate Physician 415 /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 5 autopsy performe certificate Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reenstory ad Hyuttoi. Ne MO 20201 acil 31. Date filed (Month, Day, egistrar's Signature Year) State JAN 10 2007

Registrar

Maryland 21215-0036

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Box 68760.

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Vital Records,

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the de	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□Unk		une or deat	50	Other (specify) _							
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant con	ditions	contributing to	death but	t not resulting	g in the un	derlying cause gi	ven in Part	I.	23e. Did 1			e to the cause Probably 4	of death?
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DHMH 17 Rev 1/2001

1- State Of Death

FoAmend #5 Per FH \$18164.052\\ 457\\ 657\\ 675\ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 1 Day 20^۲0°2 JÄN ELIZABETH WHITE NICHOLSON 2:25P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROCKVILLE NURSING HOME MONTGOMERY ROCKVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year | OCT 1 1910 **220-46-2504** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 96 577-48-0446 Yrs. Director MD Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location r 28a-f show 10a. State 10d. Inside City Limits 1 Yes 2 □ No MD MONTGOMERY ROCKVILLE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or iteme 23a or the Medical Examinar must be 303 ADCLARE ROAD 20850 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE HEALTH CARE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental is marked DR. ELIJAH WOOTON WHITE FLORENCE PYLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra CINDY CULP/WIFE OF NEPHEW 1848 BURLEY RD., ANNAPOLIS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. STAUFFER CREMATORY 1/13/07 FREDERICK, MD 21. Signature of Faneral Service Licensee HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a.RENAL FAILURE YR /Medical Due to (or as a consequence of): Examiner 3 YES CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physiclen at the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical attanding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records. 1 Yes 2 No 3 Probably 4 DUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has I paga 2 s 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 Yes 2 No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funarel [Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) JANUARY 12, 2007 D0019785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRAUKE WESTPHAL, MD 1202 SEVEN LOCKS RD., #202 ROCKVILLE, MD 20854 32. Registre's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

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Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
physicie per price per pri	
physicie per price per pri	
IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day	
in the past 12 mopths? Comparison of the past 12 mopths? 1	
• V W 3 17 1 LIES 4 LINO ACTUAL	ear
1 See 1 See	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coefficient to the cause of the c	ath?
1 Yes PNo 3 Probably 4	nknown
24a. Was an autopsy findings performed? prior to completion of cleath? 1 Yes DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNo 3 Probably 4 DNO 3	vailable
performed? death? Yes 1 No 1 Yes 2 No	
1 Yes 2 No 25. Was case referred to medical examiner? Hospital:	
O 1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify)	
= 6.0 [Loc. Document of Loc. Document o	
2 Accident investigation M 1 Yes 2 No 2 Acci	
28a. Date of Injury 28b. Time of Injury 38c. Injury 38c. Injury 48c. 28c.	er,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (29b. Signature and title of certifier (29c. License number) 29c. License number (29d. Date signed (Month. Day Year)	
Second one) And manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	
1007 MD D0060475 110/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
J TEREZIA BUSH, MD 100 HOSPITAL ROAD, PRINCE FREDERICK, M	7620
State 31. Date filed (Month, Day, Year) 32. Registrat's Signature	0678 D

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. Date of Death
 Month Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 6,2007 an /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner isbure 1 Come co 105 oas ta 10 C the If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State of Months | Days | Hours | Min. | February 20,1914 | Maryland 5. Social Security Number Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Yrs. 92 Director 108-09-9119 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be it USA 21801 Funeral 1003 Riverside Dr. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Wildfowl Carver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Kenly Charles Henry Nock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28244 Riverside Dr. Ext. Salisbury, Maryland 21804 Mary Ann Bennett/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/9/07 Salisbury Crematory |Salisbury,Maryland ature of Funeral Service Licenses Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** ARCINOMA /Medical Due to (or as a consequence of): Examiner DRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has certificate 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No ۲ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Fig. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State
Registrar

Date filed (Month, Day, Year) 32. I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26 26 ARROWNDOD CT.

32. Registrar's Signature

Resource & Anacke

DO058410

1-7-06

SALISBURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Allan Peter Oram 05, January 2007 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Montgomery 6012 Southport Drive Bethesda 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1√ M 2□ F Months Days Hours Min Nov. 26, 87 Director 578-94-2545 1919 United Kingdom Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show t be notified 1 ☑ Yes 2 ☐ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 6012 Southport Drive 20814 United Kingdom Funeral ural", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Yes 2 Yes Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: Completed by 3 ☐ Widowed 4 ₺ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Consultant <u>Agricultural Development</u> item 27 is marked other other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Stanley Oram Mary Gwendolyn Greenwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 North Meade Street #17, Arlington, VA 22209 Alex Oram / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Department o Important: If any injury or once. = 5 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 1/12/2007 Brentwood, MD 21. Signa ure of Funeral 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Amyotrophic lateral sclerosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed the burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 17 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Benign Prostatic Hyperplasia autopsy performed? , page 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No

P.0. Division or Vital Records,

Peter

within 24 hours completely

State Registra

2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

Day,

29a. Certifier

(Check only one)

29b. Signature and title

31. Date filed (Month,

wy MI

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D40279

29d, Date signed (Month, Dav. Year) 1/07/2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Daniel V. Young 4530 Connecticut Avenue NW #104, Washington, DC 20008 M.D.

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician January 7, 2007 \mathbf{P}^{M} James Russell Owens Sr. 11:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/19/1942 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Days Months Hours Min. XXM 2□ F 226-54-1785 64 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland | Prince Georges Bowie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20715 3607 Maroon Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Iron Worker Rodman Local # 201 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Floyd Russell Owens Mamie V. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 stant Department of Health an Important: If Item 27 is any Injury or other trauonce. 3607 Maroon Lane Bowie, MD 20715 Antonette M. Owens/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 1/9/2007 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD Huntt Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licens 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small weeks NON cell ling /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 (es 21 No certificate 2□ No 1∐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No spital: 1 inpatient 28a. Date of Injury 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Natural After thi funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 8, 2007 DS2830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Rd. #300, Amagolis, Md. 21401 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

drywall foreman

Lincoln Cemetery 01/11/07

20b. Place of Disposition (Name of cemetery, crematory or other place)

construction

Caminiti

20c. Location - City or Town, State

Brentwood, MD

18. Mother's Name (First, Middle, Maiden Surname)

Fortunata

110 Hospital Rd. #310, Prince Frederick, MD 20678

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8220 Harrison Blvd., Chesapeake Beach, MD 20732

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a State

MD

12

Giuseppe

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Signature of Funeral Service Licensee

Josephine M. Puliatti, wife

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Puliatti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wisniewski, M. D. Registry's Signature
JAN 1 0 2007

Director

Funeral

ģ

Be Completed

Funeral

Director

Physician /Medical Examiner

burialthe page

Division or Vital Records, P.O. Box 68760,

-	91. Signature of Funeral Service liben			and Address of Facility Ra					
	23a. Part1. Enter it disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only ine cause on each line. Immediate Cause (Final disease or condition and ACUTE LEUKEMIA						Approximate Interval Between Onset and Death		
cal Examiner	Sequentially list conditions, it also, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of) b. MYELODYSP Due to (or as a consequence of) c. Due to (or as a consequence of)	LAST		ROME				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopid 5 □ Other	c pregnancy (specify)		23d. Date of de Month	elivery Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY EDEMA RENAL FAILURE - CHRONIC 23e. Did tobacco use contribute to 1 yes 2 10 No 3 P								
Completed by	autopsy perform						24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No		
ē	25. Was case referred to medical 26. Place of Death (Check only one)								
0	examiner? 1 ☐ Yes 2 🔭 No	Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
ation:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of injury (Month, Day Year) 28b. Time Injury 28b. Place of injury - At home, farm, building, etc. (Specify)			28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in				
Certification				tory, office	28f. Location (Street City or Town, St	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
edical (29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due							
ž	29b. Signature and title of certifier			29c. License number 29d. D			Date signed (Month, Day, Year)		
	Peter m			D40370		1/9/07			

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 1817 M 0 more 2007 /Medical 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner niversity of Mary and Medical Center Baltimore, M) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign Country) Mary Jand 6. Sek 7. Age (In yrs. last birthday) **Funeral** 215-83-270 1 M 2 1 F Months 4ugus+1,1930 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yes 2 □ No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? U5A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. þ 3 ₩Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Holliday Mono 19a. Informant's Mame/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street Cambridge, Maryland 21613 Donte Hollida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Midshore Cremation 115/07 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P. A. 510 washington St. Cambridge 2/6/3 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 **Physician** 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe After this certificate 1☐ Yes 2 11 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) Janna

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Baltimore, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year WILLIAM PIPPEL JAN. 2007 H. JR. 1350 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year 6. Sex 1X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 83 Yrs. Director 579-38-0101 D.C. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director DELAWARE SUSSEX SELBYVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 38146 KEENWICK ROAD USA filed within 72 hours after deeth or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1942-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced WHITE "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) IRS AGENT TREASURY DEPT. 4 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event ADE. 18. Mother's Name (First, Middle, Maiden Surname) Be HAROLD PIPPEL WILLIAM FRANCES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERANE G. PIPPEL/WIFE 38146 KEENWICK ROAD, SELBYVILLE, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL 1/31/07 ARLINGTON, VA 4 □ Donation 5 □ Other (Specify) CEMETERY d Address of Facility 21. Signature HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Ceurs hoostertic Cartorera for Direcese Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physiclen and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificete has autopsy performed?

1 Yes 2 No Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ✓ EB/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No o this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospitel or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 TYes 2 □No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Porodulei 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Pippel,

Physician /Medical		Registrar 1. Decedent's Name (First, Middle, Last CLARICE			2. Date of Death Month Day JAN. 17,12007		Year	3. Time of Death 9:50 A			
Exami	ner	4a. Facility Name (If not institution, give	4b. City, Town, or Location of Death			4c. County of Death					
		6332 HARD BARGIN C. 5. Social Security Number 6. Se		If Under 24 Hrs.	-	CHARLES					
Funeral Director			7. Age (in y)	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da MAY 8, 1	930 930	VIRG	place (State or Fore ntry) INIA	
rland		10a. State 10b. County	10c.	City, Town or Lo	cation				1	10d. Inside City Lim	
Man Ffeh	tor	MARYLAND CHARLES INDIAN HE			AD MARYLAND			1 □ Yes 2 🕅 N			
with the		10e. Street and Number 6332 HARD BARGIN CIRCLE			10f. Zip Code 20640			10g. Citizen of What Country?			
Jeath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.		U.S. 13.	3. Was Decedent of Hispanic Origin? (Specify Ye			Ves or No- 14. Race - American India			
ous after oil, or iter	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	Armed Forces? If ☐ Yes 2 X No If Yes, Give 1		lf Yes, specify Cuban, Mexican, Puèrto Rican, ∈ 1 □ Yes 2X No <i>Specify:</i>			etc.) Black, White, etc. Specify: BLACK		
be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "naturel", or items 23a or 28e-f show event, the Modical Exercities must be notified at	Completed	(Specify only highest grade completed)		(Give	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
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should be ind Menta marked umatic ev	10	WILLIAM ARTIS S	SAVOY			IDA PIN	KARD S	AVOY			
d 2 s h ar 7 is treu		19a. Informant's Name/Richestis 6			_	and Number or Ru ARGIN C					
s 1 au f Hea f Hea item othe		20a. Method of Disposition	206	. Place of Dispo	osition (Name of matory or other pla	cel	Date	20c. Locatio	n - City or To	own, State	
Page ent o nt: if ry or		1 XBurial 2 ☐ Cremation 3 ☐ F → ☐ Donation 5 ☐ Other (Specify)	Removal from State			ETERY 1	120/07	KILMA	RNOCK	VA.	
permit. Pages 1 and Department of Heali Important: If item 2 eny injury or other once.		21. Signature of Funeral Service Licens				ess of Facility BE			ici o o ic		
permit. Depertimentalimportaling		12 x 11/1	all						D		
16		23a. Part 1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between									
Physician		disease or condition a Atherros cleratic Cardio Vasalan Di sun								Onset and Death	
/Medical		resulting in death)	Due to (or as a consequence of):								
Examiner		Sequentially list conditions									
D #	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying	Due to (or as a consequence of):								
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that t ed by detait	h h	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did t	23e. Did tobacco use contribute to the cause of death?			
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w require been sign	Completed					24a. Was an 24b. Were autopsy find					
has ge 2	dm							4a. Was an autopsy performed? 24b. Were autopsy findings ava prior to completion of caus death?			
n: Ti ficete		05.14					1 ☐ Yes	2 No	1 ☐ Yes	242 No	
sicial	Be	25. Was case referred to medical examiner?	lospital:	26. Place of Death (Check only one)							
Phy: r this iral d	1: To	1 Yes 2 No	28a. Date of Injury	2 Li tvodipalient 3 Li box 4 Li Nursing Home				e 5 ⊠Residence 6 □Other (Specify) 3d. Describe how injury occurred			
Afte fune	tlor	1 SNaturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) fnjury		28c. Injury at 2 Work? M 1 \(\text{Yes} 2 \(\text{No} \)						
dea dea ctor	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At				28f. Location (Street and Number or Rural Route Number,				
2 8 2 6	erti	4 Homicide determined building, etc. (Specify)							City or Town, State)		
O to O E	edical C	29a. Certifier (Check crity 29a. Certifier (Check crity 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
Hospital o	9	one) and manner stated. 29b. Signature and title of certifier							9d. Date signed (Month, Day, Year)		
o the Hospital o thin 24 hours aff the Funerel Di mpletely filled in	Σ							0/-17-2007			
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Σ	1 m Sil			1/	(2)	1				
	×	m Sil				27363		0/-1/		•	
To the Hospital of within 24 hours aft To the Funeral Discompletely filled in	M	30 Name and address of person who or	ompleted cause of death (II	tem 23a) (Type,	Drunt)			0 -1 /		•	

DHMH 17 Rev 1/2001

		1	For Stata Ragistrar	cusc I	-				t of H	lealth a	and M	lental Hyg	giene Reg. No.	007	02145
			Decedent's Name (First, M	liddle, Last)								2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medica		OPAL R. ROSS	5								January	18,	2007	3:50 P ^M
	Examine		4a. Facility Name (If not instit	-						Location of	of Death		4c. Co	unty of Death	
			Upper Chesape 5. Social Security Number	eake M			er rs. last birthday		1 Ai:	r If Under	24 Hrs.	8 Date of Birtl	1	Harfo	
	Funeral Director		215-24-4183		M 2√F F	79	Yrs.	Months		Hours	Min.	8. Date of Birtl (Month, Day 1/11/1	, _{Year)} 928	Nort	place (State or Foreign ntry) th Carolina
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72	within then	E C	Elementary/Secondary (0-	12)	College (1-4or 5+)		memak		,			Own	Home	
Sa	other	BeC	17. Father's Name (First, Mic	Idle, Last)						18. Moth	er's Nam	e (First, Middle,	Maiden Su	mame)	
Jan 1	wid by Menta Menta rrked	9	Elijah Petty	Ÿ						Lula	Mae	Edward	S		
15.6 Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dapartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel" or Items 23a or 28a-f show eny injury or other traumatic event, it a Medical Examinar must be notified at once.		19a. Informant's Name/Related Thomas A. I									al Route Numbe Cardiff		own, State, Zij 21160	p Code)
DT nore,	of Heal		20a. Method of Disposition				b. Place of Disp cemetery, cr	oosition (Na	me of other plac	(9)		Date	20c. Local	tion - City or T	own, State
	Page nent c ant: If ury or		1 ⊠ Burial 2 □ Cremat 4 □ Donation 5 □ Other	non 3 ∐Ho er <i>(Specify)</i>	emoval from	B	road Cr	eek F	rien	ds	1/23	/2007	Stre	et, Mar	ryland
//8 Balt	permit. Dapartr Import. eny Inj.		21. Signatura of Funeral Ser	vice Ligense	Lor	0.0	1	22. Name a Jarkin				e, Inc.	, Del	ta, PA	
	Physician		23 art1. Enter the dis as shock, or heart failure. mmediate Cause (Final disease or condition	e, or condition	cations that e cause on	each line.	eath. Do not e	nter the mo	de of dyin	ig, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions			(or as a con	sequence of): A (U	te r	7400	ardi	al	infan	tion	1	
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$\sqrt{\underline{\underline{a}}}$	stan: artifica ctor, p	Bec	25. Was case referred to me examiner?			PE 10-			-	26. Plac	e of Deat	th (Check only o	ne)		
چک	hyeic his ce	2	1 ☐ Yes 2 ☐ No	Н	_		2 ER/Outpat			4 L N	ursing Ho	me 5 Resid			uty)
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$\propto \frac{\overline{s}}{2}$	death death stor: , the f	icat	3 Suicide 6 □ C	vestigation ould not be	28e Plac	e of Injury - A	At home, farm,			105 2	INO	28f. Location /5	Street and N	Number or Rur	ral Route Number,
공	Ital or A rs after ral Directed in by	Certification:	4 Hornicide	etermined	build	ding, etc. (Sp	ecify)					City or Tov	vn, State)		
9	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai			ner: On the							and due to the red at the time,	date and pl	ace, and due t	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of co	etifier	1/	0		-	νA.	6 number	1,0			signed (Month,	, Day, Year) 18,2007
	2		30. Name and address of pe	rson who co	empleted cau	use of death		e Print)			-	v. Bel		ma	01011
	Sta		31. Date filed (Month, Day,			Registrar's S	ignature		1250	year	سا	r. Bel	411	UIII	21014
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Examiner the burial-tran Division or Vital Records, P.O. Box 68760. physician use as t for ed by the a s been signed b page funeral or Attending filled in by

s after decarl Director: After within 24 hours a

To the Funeral I

completely filled

Physician

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Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consec	quence of):				
	resulting in death) Last	Due to (or as a consec	quence of):				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 ☐ Ectopic			23d. Date of deli Month	very Day Year
by Pł	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco u	use contribute to	the cause of death?
ed b	Hoperleuria	- reguling	endunca		1 ☐ Yes 2	□No 3□Pro	bably 4 Hinknown
Completed	mulipe sch	un's			24a. Was an autopsy performed? 1 Yes 2 ♣ No	death?	topsy findings available ompletion of cause of
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
70	1 Yes 2⊒ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [OOA Other: 4 Hoursing	Home 5 ☐ Residence	6 □Other (Spec	ify)
	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred	
Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	d Number or Ru	ral Route Number,
lical (29a. Certifier 1 Certifying Ph	nysicîan: To the best of my kni niner: On the basis of examina	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause(s curred at the time, date and) and manner as d place, and due	stated. to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

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29d. Date signed (Month, Day, Year) D (8019 JAN 22,200)

MACERSTOWN MO 21740 340 VACANT DATTA 20 MILL ST 31. Date filed (Month, Day, Year)

29c. License number

State Registrar 29b. Signature and title of certifier

Brenda Gail Ryans

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 6, 2007 Medical Examiner 1855 hrs BRENDA GAIL RYANS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Prince George's 5429 56th Avenue Riverdale 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** oreign Months Days Hours Director Oct. 11, 1964 1 M 2 X F 42 Country) unknown Usual Residence of Decedent 10a. State 10c. City, Town or Location í 10b. County 10d Inside City Limits 28a-f show Yes 2 X No Riverdale Prince Georges death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? at 20737 USA 5416 54th Avenue. 23a Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygener. Inportant: I fiten 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner. f Yes, Give Year Widowed Divorced 1 Yes 2X No specify: Specify **Black** 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Tax Preparer Jackson Hewitt 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Freda Ryans Cassie Smith ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6145 64th Ave. #3 Riverdale, MD. 20737 Freda Burgwyn/mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State crematory or other place 1 X Burial 2 Cremation 3 Removal from State Ft.Lincoln Cemetery 1 - 13 - 2007Brentwood, MD. Donation 5 Other Specify 22 Name and Address of Facility
Marshall's Funeral Home, Inc.
4217 9th St. N.W. Washingto 21 Signature of Funeral Service License Washington, D.C. 20011 Paul Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause events resulting in death) Last Due to (or as a consequence of) and Physician/Medical g physician a the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate page ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 2 No 28a. Date of Injury (Month Day Year) Jan 6, 2007 After Manner of Death 28b. Time of Injury 28c. Injury at Work 28d Describe how injury occurred Certification: s after dea. Subject shot Natural 1840 hrs 5 Pending 1 Yes 2 🗸 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 5429 56th Avenue, Riverdale, MD within 24 hours a To the Funeral I 4 V Homicide determined (Specify) Sidewalk 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E January 7, 2007 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

OCME 2006

DHIVIH 17 Rev 1/200

31. Date filed (Month, Day Year)

32. Registrar's Signature

		1 - For State Registrar	State of Maryland / D	epartment of Certificate of	Health and M	fental Hygier	2007	02148
Physicia /Medic	al I		A-SERENA RICHMO		and another of Dooth	JAN. 10	Day Year 0, 2007 4c. County of Death	3. Time of Death 2:14 A M
Funeral Director	er	4a. Fecility Name (If not institution, giv 9506 SILVER I 5. Social Security Number 6. S 578-48-5521	FOX TURN ex 7. Age (In yrs. last birth	CL			PRINCE GE	
1 and 2 should be filed within 72 hours after deeth with the Maryland theelih and Mental Hygiens Hygiens 71 is marked other than "natural", or items 23e or 28e-f ahow ther traumatic avent, the Madical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD. PRINCE (10e. Street and Number	DIGGS Type, Print) 10c. City, Town 10	CLINTON 10f. Zip Code 2 13. Was Decedent of If Yes, specify Cu 1 Yes 2 No Decedent's Usual Occ Give kind of work don life. DO NOT use retiin PASTOR Mailing Address (Street	O735 Hispanic Origin? (Spban, Mexican, Puerto o Specify: upation e during most of worked) 18. Mother's Nam BETS et and Number or Run R FOX TURN	e (First, Middle, Maid SY COL	Citizen of What Cou U.S.A. 14. Race - Amer Black, White Specify: BI . Kind of Business/I CHURCH ten Sumame) E by or Town, State, 2	10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry? rican Indian, , etc. ACK Industry
permit. Peg Department Important: I any njury o once.		4 Donation 5 Other (Specification of Funeral Service Lices)	free M00091 plications that caused the death. Do none cause on each line.	NCOLN CEME 22. Name and Add CHAMBERS 5801 CLEV	TERY 1-12 ress of Facility FUNERAL HO ELAND AVE.	ME & CREM.	RENTWOOD, ATORIUM, P LE, MD. 2	0737 Approximate Interval Between Onset and Death
Physician Management Manage	icai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. DEHYDRATION Due to (or as a consequence of PARKINSON S DI Due to (or as a consequence of	SEASE f):				2 WEEKS 5 YEARS
of the death certificat by the ettending phy teched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date of deli	very Day Year
es the gned be de		Part II. Other significant conditions (contributing to death but not resulting in	the underlying cause of	given in Part I.			the cause of death? obably 4 Unknown
The law ate has b page 2 st	Completed					24a. Was an autopsy performed 1 Yes 2 🔀	? prior to death?	topsy findings available completion of cause of 2 No
. <u>></u> P	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA	Whar	th (Check only one) ome 5X Residence	e 6 □Other (Spec	cify)
ath. rr: After	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Rending investigation of the determined	n Ogo Phon of Injury Athena fo	M 1	□Yes 2□No	28d. Describe how in 28f. Location (Street City or Town, St	t and Number or Ru	ral Route Number,
To the Hospital or Atterwithin 24 hours efter de To the Funeral Directo completely filled in by the	Medicai C	29a. Certifier (Check only one) 29b. Signature and hitle of certifier	nysician: To the best of my knowledge miner: On the basis of examination and and manner stated.		time, date and place, opinion, death occur		e(s) and manner as and place, and due Date signed (Monti	
 		30. Name and add ss of person who	School I	ype, Print)	2020003	J	AN. 10, 2	007
Sta		STEPHEN BLOC 31. Date filed (Month, Day, Year)	32 Agistrar's Signature	MARTHA CUR	TIS DR., A	LEXANDRIA	, VA. 223	02

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 9, **Physician** Rose Grace Rudasi11 12:10 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 97 Hummingbird Court Dunkirk Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Feb 13, 19 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 578-32-6468 90 Yrs. Director 1916 Maryland Usuat Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene.
Important: if item 27 is marked other then "natural", or itema 23e or 28a-f show any injury or other traumatic event, the Medical Examinatings the notified at once. 10a. State 10b. County 10d. Inside City Limits MD Anne Arundel Dunkirk 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 97 Hummingbird Court 20754 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Scheungrab Rose Schwingenschlogl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Rudasill (son) 97 Hummingbird Ct. Dunkirk, MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan 13 1 🛱 Burial 2 □ Cremation 3 □ Removal from State St. Peters Ch. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Waldorf. MD 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myo cardial **Physician** Interction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). or Attanding Physician: The law requires that the death certificate be executed Exami physicien and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ icete has been signification of page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗵 No 1 Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 🖄 Natural death. 1 ☐ Yes 2 ☐ No Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by filled in by 4 - Homicide Fo the Hospital † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 10, 2007 038563 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 134 Oversville Rd, West River layne Bierbaum ma 31. Date filed (Month, Day, Year) 32. Registras Signature State 2007▶ Registrar

		1 - For State Registrar AMEND #26perMD1		-	artment of F			giene Reg. No.	007	02150	
Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death	
/Medi		ROBERTO	SANDOVAL					, 200]]:08A M	
Examir	ner	4a. Facility Name (If not institution, give Washington Advent	ist Hospital		4b. City, Town, or Takoma	Park	- 75		ounty of Death Ontgome		
Funeral Director		EE7 7E 3503	XM 2□F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours I	Min. 8. Date of Birth (Month, Day June 6	1932	Col	nplace (State or Foreign Intry) LIVIA	
and **		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits	
Mary	៦	MD Montgom	erv	Takı	oma Park					1 ⊠ Yes 2 ☐ No	
28a	Director	10e. Street and Number	0-1	1001	10f. Zip Code			10g. Citize	n of What Cou	untry?	
3a or		7006 Westmor	eland Ave			20912		τ	J.S.A.	,	
permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-1 show important: If item 27 is marked other then "naturel", or items 23a or 28a-1 show important: If item 27 is marked other the most partial Exactly at most be notified at ONCE.	by Funeral	11. Marital Status 1 Narried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes		Was Decedent of H If Yes, specify Cuba 1 ☑ Yes 2☐ No		? (Specify Yes or No- Puerto Rican, etc.) Bolivian		Race - Amer Black, White pecify: Whi	, etc.	
"nature	Completed I	15. Decedent's Edu (Specify only highest grad	cation	(Give	dent's Usual Occup	durina most of	f working	16b. Kind	of Business/Industry		
filed withir Hygiene. other then	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Upholstry	,	r	,	Self En	mployed	
d be file ental Hy ced oth c event	To Be	17. Father's Name (First, Middle, Last) Unknown				18. Mother's	Name (First, Middle,	Maiden Si	umame)		
should be nd Mental marked	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number o	Unknown or Rural Route Numbe	r, City or 1	rown, State, Z	io Code)	
and 2 leith a 27 is er tres		Mercy S. Flores-	Daughter	7006	Westmore	land A	ve Takoma	Park	, MD 20	912	
of He of He fiterr		20a. Method of Disposition 1 ☐ Buriat) 2 ②Cremation 3 ☐ F	lamanal from Ctata	cemetery, crei	sition (Name of matory or other place		Date	20c. Loca	tion - City or T	Town, State	
Pages ment of lant: If it		4 □ Donation 5 □ Other (Specify)		1.4	e Park Cr		/8/07		erdale,		
permit. Departm Importate ony inju		21. Signal to of Funeral Service Licens	Kurech	2	46 N. Was	hingto	snowden F n St Rockv	ille			
Physician /Medical		23a. Pand. Enter the disease, or complished, or heart failured List only of Immediate Cause (Final disease or condition resulting in death)	7 1	10 SC		(Car	diovasca	lara	Lisea	Approximate Interval Between Onset and Death	
icate be executed by physicien and burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):	scular e psi	1	cci dont				
The law requires that the death certificate be execut ate has been signed by the attending physicien and page 2 should be detached for use as the burial-tran	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6	el death 3	Ectopic pregnancy Other (specify)	,		23	d. Date of deli-	very Day Year	
quires that n signed b	þ	Part II. Other significant conditions con	ntributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.			contribute to	the cause of death?	
	Completed						24a. Was a autop perior 1 □ Yes	SV	24b. Were aut prior to c death?	topsy findings available ompletion of cause of	
iiclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		11.		Death (Check only or	ne)			
Physiclan: this certific ral director,	은	1 ☐ Yes No 27. Manner of Death	1 In atient 2 28a. Date of Injury			4 🗆 (4013)	ng Home 5 Resid			ity)	
Attending I r death. ector: After by the funer	ation	Natural 5 Pending investigation	(Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ⊟No	28d. Describe h	ow injury o	occurred		
P efe d □	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow	treet and i	Number or Rui	ral Route Number,	
the Hospital thin 24 hours e the Funeral I	cal	(Check only 2 Medical Exami	sician: To the best of my known: On the basis of examinating and manner stated.	ation and/or in	vestigation, in my o	pinion, death	occurred at the time, of	date and p	lace, and due	to the cause(s)	
To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month	, Day, Year)	
]		· all			D00	6010	0	01	-03-	07	
•		29b. Signature and title of certifier 30. Name and address of person who compared to the street of	ompleted cause of death (Ite	m 23a) (Type,	Print) Univ.	si Ji	BLUD Se	MI	Sul.	402Z	
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 egistrar's Sign	ature	auti)	,, ,				10000	

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		•	1 - For State Registrar				C	ertifica	te of L	Death			Reg. No	o.			
			1. Decedent's Name	e (First, Middle, L	.ast)							2. Date of De				3. Time	of Death
	Physicia /Medic		BETTY RE	DMAN STI	LL							JANUA	RY 8		007	13:	35 P ^M
	Examin	er	4a. Facility Name (I	_		mber)		4b. City	, Town, or	Location of	of Death		40	. Count	ty of Deatl	h	
- T		w.	111 CEDAI	R STREET				CHE	STERT	LOMN			KENT				
11 42 1	Funeral Director		5. Social Security N 215-20-1		Sex 1 □ M 2 🛣 F	7. Age (in)	yrs. last birthda 79 Yrs.	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	nth 192	7	9. Birtl	nplace (Stat untry)	e or Foreign MD
100			Usual Residence of	Decedent													
	ylan		10a. State	10b. County		10c.	City, Town or	Location								10d. Inside	City Limits
	Mar Han	ō	MD	KENT			CHESTE	RTOWN								1 X Y	es 2∏No
	288	Director	10e. Street and Nur	mber				10f. Z	p Code	-	10g. Citizen ol What					untry?	
	ath with 23a or	rai D	111 CE	DAR STRE	ET				2162				USA				
	ep .	Funeral	11. Marital Status		12. Was Dece	rces?	n U.S. 13	I. Was Dece	edent of Hi	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecfy Yes or No Rican, etc.)	0-		ice - Amei ack, White	rican Indian, e. etc.	
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Iteal Examinat must be multilied at	þ	1 Never Marri 3 Widowed	ied 2 X Married 4 □ Divorced	1 □ Yes If Yes, Giv Year or D	/ 0			1 ☐ Yes 2K No Specify:					Specify: WHIT			
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212	l within plene. r than "	omo	Elementary/Seco	ondary (0-12)	College (1-4or 5+)		K MAN		,				FINA	NCIA	L	
D	be filed htal Hygid of other event, II	BeC	17. Father's Name	(First, Middle, La	st)			18. Mother's Name (First, Middle, Maiden Sumame)							me)		
<u>a</u> n	should be nd Mental marked c	To B	PHILIP 7	r. Jones						MA	RY B	EATRICE	AT	KINS	ON		
ary	d 2 should th and Mer 7 Is marke treumatic		19a. Informant's Na	-			19b. Ma	iling Addres	s (Street a	nd Numbe	er or Rur	al Route Numb	er, City	or Town	n, State, Z	ip Code)	
	and 2 valth valth or tre		CHARLES W. STILL/HUSBAND 111 CEDAR STREET, CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or														
ore	es 1 and of Healt f Item 2 r other		1 🔀 Burial 2 Cremation 3 Removal Irom State cemetery, crematory or other place)										- City or	Town, State			
Ĕ	Pag ment ant: I			5 Other (Spec		Cialo (CRUMPTO	N CEM	ETERY		01/	13/2007	CRU	MPT	ON, N	MD	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HO 130 SPEER ROAD, CHESTERTOWN, MD 21620												AL HON	Æ, PA	
1.55			23a. Fart1. Enter t	he disease, or co	mplications that of	aused the d	death. Do not e	nter the mo	de of dyin	g, such as	cardiac	or respiratory a	rrest,			Approxin	Between
	Physician		Immediate Cause	(Final	A	curte	Musl	bgen	un A	1011	Man					Onset an	nd Death
	/Medical		disease or condition resulting in death)	4	Due to	(or as a con	sequence of):	0 8-101	783	····	100					10 //	17[11-3
	Examiner				_												
	. <u>, , , , , , , , , , , , , , , , , , ,</u>	ē	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nditions, nmediate	Due to	(or as a con	sequence of):										
	uted d ansit	Examine	Cause (Disease or that initiated events	injury 1													
ó	exec an an rial-tr	Exa	resulting in death)	Last	Due to	(or as a con	sequence of):										
Box 68760,	death certificate be executed e attending physicien and nd for use as the burial-transit	cai			d												
89	ng ph	Ned	IT TEMALE:														
300	attendi for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy													ate of deli	,	Year
P.O. E		Physician/Medical	in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	Ne	4□Pregr 9□ Unkn	nant at time own	ol death 5	Other (s	pecity)					N	OHI	Day	1 641
	that ned by deta	P P	Part II. Other signif	ficant conditions	contributing to d	eath but not	resulting in the	underlying	cause give	en in Part I		23e. Did	tobacco	use cor	ntribute to	the cause of	of death?
ords,	96 P	d by										10	Yes 2	. □ No	3 ☐ Pro	obably 4	nknown
Date particular partic										-					`		

To the Hospitel or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh Division of Vital Reco

1
24a. Wa aut

24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? ecity)

1 ☐ Yes 2 ☐X	<u>l</u> o	1 Inpatient	2 ER/Outpatient	3□ (DOA CUITO	I 🗌 Nursing H	flome 5 Besidence 6 □Other (Specify)
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	1	28b. Time of Injury	м	28c. Injury at Work?	2 🗆 No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, larm, stree	t, lact	ory, office		281. Location (Street and Number or Rural Route Number City or Town, State)

29a. Certifier (Check only one)	Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.

(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susak, Ross 516 In D

State Registrar

Medical Certification; To Be Compile

32. Registar's Signature

DHMH 17 Rev 1/2001

13

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** FRANCES TURNER 4 0.7 /Medical 5:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X 578-22-0939 Director 91 -11 - 15ARLINGTON, VA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f sh Examiner must be notified 1 Yes 2 □ No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2, and 1 july or other traumatic event, the Medical Examinar "...... once. 3333_WISCONSIN AVE NW #804 20016 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXIVo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes \$CTNo þ Specify: BLACK 3X Vidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE NURSE ARMY DISTAFF HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK ROBINSON 2 JULIA JACKSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R 9919 PARK ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) LANHAM, MD 20706 JOHN D. ROBINSON-BROTHER 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMO. 1-10-07 LANDOVER, MD PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY SPANGLER FUNERAL HM. 524 8TH ST. NE WASHINGTON, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ene cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** DECUBITUS ULCER SACRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DIABETES MELLITUS attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ OBSTRUCTIVE LUNG DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown CHRONIC Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 211 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DASGUPTA,

31. Date filed (Month, Day, Year) JAN 1 1 2007

DasG yzla

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

7600 CARROLL AVE #510 TAKOMA PARK,

64699

29d. Date signed (Month, Day, Year)

07

			For State Registrar	State of Maryland		artment of H		Mental Hy	/giene	02153
	Physici	an	Decedent's Name (First, Middle, Last)	1.1				2. Date of D Month		3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give:	treet and number)	19	4b. City, Town, or	Location of Dea	th	4c. County of E	Death O.OIAM
1	Examir	ıer	27522 Edgew	. 17 . 1		Salis	bury		Wice	mico (o.
	Funeral Director		5. Social Security Number 6. Sec. 18	7. Age (In yrs. Id	ast birthday) Vrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year) 9.	Birthplace (State or Foreign Country) ACINY I QND
	TO.	'	Usual Residence of Decedent 10a. State 10b. County	100 Cita	, Town or Lo		I		1 / 0 1	10d. Inside City Limits
	Maryla -f shov fied at	tor	MD Worces		10W10120	Hill				1 Tes 2 No
	or 28a	Funeral Director	10e. Street and Number	1		10f. Zip Code			10g. Citizen of Wha	t Country?
	eath w	erail	11. Marital Status	touse Kd. 12. Was Decedent Ever in U.S	3 13 1	Vas Decedent of Hi	63	Specify Yes or N	0- 14. Race - /	American Indian,
92	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show he Madical Exeminer must be maillied at	/ Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give		Was Decedent of Hi IYes, specify Cuba I□Yes 20 No	n, Mexican, Puè Specify:	rto Rican, etc.)	Black, V	Vhite, etc.
90	thours stural',	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	tent's Usual Occupa	ation		16b. Kind of Busine	P/ACK ess/Industry
21215-0036	ithin 72 ne. Madi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done of OO NOT use retired	during most of wo	orking		
	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)		rav	n-er	18. Mother's Na	me (First, Middle	FARMe	IR +NO
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, the Medical Examiner must be notified at	To Be	William Edn	sard Taylo			Mary	Eliza	beth	laylor
Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Ty	(daughten)	19b. Mailir		and Number or A	_	lisburg, o	01001
ore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. Pl	ace of Dispo	sition (Name of natory or other place	1	Date	20c. Location - City	
Baltimore,	t. Pa rtmer rtant rjury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	IAY		Ate (ein			SNOW H	
Ba	permit. Departimport any inj		Dammie 4	Shar	B	FUN era	11			md 21801
			23a. Part . Enter the disease, or complishock, or heart failure. List only or	cations that caused the death e cause on each line.	. Do not ent	er the mode of dying	g, such as cardia	c or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		I Infa.	-ch			
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	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	isnee of).					
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Box (eath certifica attending ph for use as th	an/Me	230. Was decedent pregnant	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of	•
P.O. E	the the	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at time of de 9□ Unknown		Other (specify)			Month	Day Year
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Records,	w require been si should I									Probably 4 Unknown
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Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		100		ath Check only		relative's.
of	Phya this ral dir	n: To	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury (Month, Day Year)	28b. Time of	t 3 DOA Other	4 🗀 Nursing		idence 6 Mother (5	pocity) Address
Division	Attending I r death. ector: After by the funer	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury	M 1 🗆 Y	res 2 □ No			
Divi	or At after d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location City or To	(Street and Number of wn, State)	r Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	(Check only 2 Medical Exemi	lician: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the time restigation, in my op	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the comple	Mec	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (M	onth, Day, Year)
)	SOX		* /· X W				05619	7	1/11/20	>> '7
6			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) 8 Ne	when I	+ Sal	13 5 0	1815 C
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	9 . 00 .				<u> </u>
	riegisti	er!	JAN 1 1 20	UI BERLIE S	J. G.					

			For State Registrar	State	of Maryla		artment of F		d Mental Hy	giene Reg. No.200	7 02154		
7	Physici		1. Decedent's Name (First, Mi						2. Date of De Month	ath	3. Time of Death		
100	Physici /Medio		Elsie Kath	nerine Voi	n Wald				Januar				
1	Examin	er	4a. Facility Name (If not institu		,		4b. City, Town, o			4c. County of	Death		
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П	Funeral Director		579-20-9451	1 □ M 2 🕅	F 8.5		Months Days		Ain. (Month, Da	y, Year)	Country) ashington DC		
dellar	70	β.	Usual Residence of Decedent						Aug. 2	O 9 I J Z I W			
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	ms 2; mus	Funeral	11. Marital Status	12. Was I	Decedent Ever in	n U.S. 13.			? (Specify Yes or No uerto Rican, etc.)	United St	American Indian,		
9	after or ite		1 ☐ Never Married 2 ☐ M	larried 1 ☐ Y	d Forces? es 2X No , Give				uèrto Rican, etc.)		White, etc.		
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d 2	i filed I Hygi other ent, t	Be C	17. Father's Name (First, Midd	fle, Last)				18. Mother's N	Name (First, Middle,		- Inc		
Maryland 21215-0036	uld be Jenta rked tic ev	To B	Daniel J. Pla	ISS				Elsie	R. Schanz	Z			
lary	and Name	7 5	19a. Informant's Name/Relation	onship (Type. Print)	Daughte	r 19b. Mailir	ng Address (Street	and Number or	Rural Route Number	er, City or Town, Sta	te, Zip Code)		
	and sealth m 27	3	Katherine E. N	iederhelm						sburg, M	20879		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Crematic	n 3 □Removal fr	om State	b. Place of Dispo cemetery, crei	sition (Name of natory or other place Cemetery	e) Ja	Date	20c. Location - City	y or Town, State		
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			23a. Part1. Enter the disease shock, or heart failure.	or complications the ist only one cause of	diac or respiratory a	rrest,	Approximate Interval Between						
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Вох	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Li	outcome pf pre ve birth 2 🗆 F	etal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year		
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or Vital Records	The lay ate has page 2	Completed	• • • • • • • • • • • • • • • • • • • •							rmed? prior 2 X No 1 ☐			
/ita	i ician ; Th certificate ector, pag	Be (25. Was case referred to med examiner?					26. Place of D	Death (Check only o				
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n C	ding P. After funer	ö	27. Manner of Death 1X Natural 5 □ Pen		ate of Injury Month, Day Year	28b. Time of Injury	Work		28d. Describe h	low injury occurred			
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 ☑ Certifier (Check opt) 2 ☐ Media	ying Physician: To	the best of my I	knowledge, deatl	occurred at the tin	ne, date and pla	ace, and due to the	cause(s) and manne	r as stated.		
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	To t	2	29b. Signature and title of cert	filer /	W -		29c. License			29d. Datersigned (M	Ionth, Day, Year)		
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	,-		30. Name and address of pers				,	to 100	Doolerri 1 1	, MD 200	250		
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	Registr	ar	JAN 1.	L 2007	There	K A	we						

			1 - State of Maryland / Depa	artment of Health and Natificate of Death	Mental Hygien	71111/11/153
	Physici		Decedent's Name (First, Middle, Last) ELIZABETH WALKER VAN WINKLE		2. Date of Death Month JAN 9	2007 3. Time of Death 10:20A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 20320 BUCKLODGE ROAD	4b. City, Town, or Location of Death BOYDS		c. County of Death
	Funeral Director		5. Social Security Number 216-60-2502 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 41 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea AUG 8 19	9. Birthplace (State or Foreign County) WASH., DC
	Maryland a-f ehow	tor	10a. State 10b. County 10c. City, Town or Lot MD MONTGOMERY BOYDS	cation		10d. Inside City Limits 1 ☐ Yes 2 ❤️No
	th with the 23a or 28	ai Director	10e. Street and Number 20320 BUCKLODGE ROAD	10f. Zip Code 20841	10g. (Citizen of What Country? USA
036	within 72 hours after deeth with the Maryland ene. then "natural", or items 23s or 28s-f ehow ha Modical Exemples can be notified at	i by Funerai	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cyban, Mexican, Puerto I 🗌 Yes 2 🖾 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	d within 72 ho piene. r then "natu	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired) EMPLOYED	king	Kind of Business/Industry RAPHICS DESIGN
Maryland :	should be filed ind Mental Hygid marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Last) HAMMET WALKER HOUGH		e (First, Middle, Maide YN THOMAS	
	and 2 sho lealth and m 27 ie m her traum		HAMMET HOUGH / FATHER 2032	g Address (Street and Number or Rui 0 BUCKLODGE RD	., BOYDS	, MD 20841
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination matter and 200.000.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	15/07 BC	Location - City or Town, State OYDS, MD	
8	\$9.E € 8		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	HILTON FUNERAL P.O. BOX 86, B. er the mode of dying, such as cardiac		Approximate Interval Between
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	x1 le po190	ning	Onset and Death
P.O. Box 68760,	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical Ex	d	DEctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	quires that t n signed by uld be deta	ρ	Part II. Dther significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		o use contribute to the cause of death?
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of Vita	Physician: The lar this certificete hes al director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	t 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence	
Division of Vital Records,	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: After toompletely filled in by the funera	ertification;	27. Manner of Death 1 Natural 2 Accident Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Time of Injury 28b. Place of Injury 28b. Time of Injur	Work? 1 □ Yes 2 □ No	undoug	inty occurred is hed smill hicle with actorsed and Number or Rural Route Number, Rd atel 20 300 BUCK 1000 Rd
Δ	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) Medical Examina: On the basis of examination and/or invance) and manner/stated.	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cause	(s) and manner as stated.
	To the within: To the comple	Mec	29b. Signature and title of certifier	29c. License number DOSY28		Date signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, ITER NO OME	Print) 2101 med	cal Par	n 11,2007 K Dr 20502
	Sta Registi		JRA N BREKEK MOOME 31. Date filed (Month, Day, Year) JAN 12 2007 Marin M.	Sperke	/	

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JANUARY 2007 **Physician** 9:01 AM WALK JR. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE"S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2X F Yrs. SOUTH CAROLINA JULY 9 1933 248-42-8726 73 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show enty injury or other traumatic event, Ita Medical Examinat must be notified at once. 1 X Yes 2 □ No MD PRINCE GEORGE'S BLADENSBURG Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5999 EMERSON STREET #309 20710 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 XYes 2 No ARMY If Yes, Give Year or Dates: Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: Ś 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LANDSCAPER PRIVATE 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CONNIE GREGORY FLOYD WALK SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 433 ATLANTIC ST S.E. # 104 WASHINGTON, DC 20032 CHERLY GILMORE/NIECE 20b. Place of Disposition (Name of **22** Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 1/16/2007 CHELTENHAM, MARYLAND 21. Signature of Fundral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** U(mon as /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien end s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pr IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Frobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 2][] No 22 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA SIL 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mm, M 00060362 mpleted cause of death (Item 23a) (Type, Print) . 4666 5. oes promise Dr., Bowil 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death nderson muar 2007 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Egunty of Death restertour VER If Under 24 Hrs. ocial Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 02/23/1914 Birthplace (State or Foreign Country) Months Days Min 1 M 2 F 92 Hours 215-36-2063 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No QUEEN ANNE'S MARYDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6723 SUDLERSVILLE ROAD 21649 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No If Yes, Give X 1 ☐ Yes 2 XNo WHITE Specify: Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS ANDERSON BERTHA MEREDITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA CHANCE/DAUGHTER 783 CHANCE ROAD, CLAYTON, DE 19938 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SUDLERSVILLE CEMETERY 01/13/2007 SUDLERSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) and Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed) 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed v
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any injury or other traumatic event, that

Physician

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Director

rthan "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at

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filed within 72 hours after death

Baltimore, Maryland 21215-0036

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Box 68760

Division of Vital Records, P.O.

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed دلك 1 Yes 2 No 25. Was case referre medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and til of certific 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

who completed cause of death (Item 23a) (Type, Print) BlogB Chestertown MD 21620 32. Regi

within 24 hours a To the Funeral C completely filled To the Hospitei

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 10, Day 2007 **Physician** 9:35 p м Joan Whaley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7580 Easton Club Drive Easton Talbot If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months New Jersev 156-24-6423 73 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 286-f show traumatic avent, the Medical Examinar must be notified at 1 Yes 2 No Director Talbot Maryland Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7580 Easton Club Drive 21601 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð Specify: 3 MWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene. Importent: if itam 27 is marked other than "1 any injury or other traumatic avent, the Med any injury or other traumatic avent, the Med app. gange. Elementary/Secondary (0-12) College (1-4or 5+) 12 Marketing Consultant Consumer Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Buffardi Karin Gerlo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Harbor Heights Dr., Center ort NY Date 200. Location - Cit Karin Whaley Brown/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State MidShoreCremationCenter 1/12/2007 Cambridge, MD 1 4 ☐ Donation 5 ☐ Other (Specify) ²², Name and Address of Facility Mid Shore Cremation Center, P.O. Box 1464, 2272 Hudson Rd., Cambridge, MD 21613 21. Sgy ture of Funeral Sgrivice Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomy of at hy Von schemic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially liet conditioned if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month 4☐Pregnant at time of death 5 Other (specify) tha 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 2 2 No 1 ☐ Yes Division of Vital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Other: 4 Nursing Home esidence 6 Other (Specify) 2 After thi 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describ how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funaral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0064036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Idlewild Ave Baston, mid 2160 Shanahan 522 31. Date filed (Month 32. Registrar's Signature State 200

DHMH 17 Rev 1/200

Registrar

		1 - For State Registrar		aryland / Dep Co	partment of			Re	g. No.	07	02160
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The law re ate has bee page 2 sho	Completed						_	a. Was an autopsy performe	ed?	Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
icien: artific actor.	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Chec	k only one)		
To the Hospital or Attending Physicien: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatier 28a. Date of Injur (Month, Day		of 28c. Ir	Other: 4 Nur njury at Work? I Yes 2 N			ce 6 ∏Oth rinjury occur		(y)
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6/20		30. Name and address of person who co	ompleted cause of de	out Ocean	City Blud	Benni	Maryland	21811			
St Regis	tate trar	31. Date filed (Month, Day, Year) JAN 1 1 20	32. Pogistra	Old Ocean	hast!						

Physician /Medical Examiner Division or Vital Records, P.O. Box 68760 the

Physician

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Funeral

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r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "in any hijury or other traumatic event, the Medit once.

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

attending physician for use as the burla To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year	
ed by Pl	Cardiomyopathy		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
Complet	Coumadin toxic	A ^	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
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ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical Certification:	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
ž	29b. Signature and title of certifier • La Khvinder We	adhwa, MD Lull 29c. License number DOOG 3498	29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lakhvinder

JAN 26

31. Date filed (Month, Day, Year)

Wadhwa

32 Hegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Concept Name First Matter, Law John v. Amy Sr.	1. Doublet Name (First, Model), 124 10 10 10 10 10 10 10 1			•	For State Registrar	State of Maryta		rtificate of		·	Reg. No.	0 0 1	- Ines	. 0 =
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Social Security 150 - 2016 Se	\$ 5000 Beauty Number 50 ks		Examin	er								•		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗍 1 - For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Brown 9:15am M itsue 26 2007 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel 1715 Trent Street Crofton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1 M 2 X F Vrs 76 218-68-0846 March 15,1930 Japan Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 XYes 2 □ No MD Anne Arundel Crofton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1715 Trent Street 21114 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Caucasian Yes. Give 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sadako Hara Kaoru Yoshimura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl L. Brown / Son 1715 Trent Street Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan.29, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, MD 5 Other (Specify) 2007 Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Smooth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23d. Date of delivery ath 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? g in the underlying cause given in Part I. 3 Rrobably 1 Tyes 2 □ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 No 1 Yes 2,2 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Examiner Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

ul Hygiene. Jother then "natural", or Iteme 23a or 28e-1 ehow vent, tra Madical Examinar must be notified at

Peges 1 end 2 should be filed within 72 hours effer nent of Heelth and Mental Hygiene. snt: If item 27 is marked other then "natural", or ite ury or other traumatic event, the Medical Examine.

permit. Pege Department o Important: If i eny injury or

Baltimore, Maryland 21215-0036

death with the Maryland

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Completed by

Be

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Certification:

Medicai

4 Homicide

The law requires that the death certificate be executed

the Hospitel or Attending

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de. 4 Pregnant at time of death 9 Unknown
Part It. Other significant condition	ns contributing to death but not resultin

Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Decritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature and title of oprtifier 29c. License number Rhee MD

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Bestyck Rd Sute 300 Annapolis MD

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State Registrar 31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Marilyn D. Bateman 6:35 AM 25 2007 Jan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis HealthCare -The Pines Easton Talbot | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jul 21, 1933 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 🗶 73 Director NY 079-26-7879 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If Item 27 ie marked other than "natural", or Items 23a or 28a-1 show ary or other treumatic event, tre Medical Examinat must be notified at 1 ☐ Yes 2 No Easton MD Talbot Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21601 8688 Misty Brook Way Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2√No fYes, Give 1 ☐ Never Married 2 ☐ Married timore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Import Co. Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Combs Hughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar important: If Item 27 is any injury or other treughts: 8688 Misty Brook Way, Easton, MD 21601 Candaca Schwadron 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1)(X) Burial 2 Cremation 3)(X) Removal from State Greenfleld Cemetery Jan 29, 2007 Hampstead, NY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility
Fink Funeral Home, P.A. 426 Crain Hwy S, Glen Burnie, MD 21061 M01148 K. Gregory Tink 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or candition resulting in death) **Physician** Means /Medical Examiner certiminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Theroschusis, Due to (or as a consequence of): Box 68760. Physician/Medical ettending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ in lan's disease 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 24a. Was an autopsy performed? page this certificate 2 No 1 ☐ Yes or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 3□ DOA Medicai Certification; To After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation s efter death I Director: A id in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eff
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completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marker as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of person who competed cause of death (Item 23a) (Type, Print) Diddimans Lane, Easton, MD 21601 rowler 31. Date filed (Month, Day, Yar) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 2 9 2007

arilyn Bateman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Jank 45A 5 90. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** no 12 C. / Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M XX Director 79 April9,1927 Wash. 213-20-1491 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or than "natural, or items 23a or 28a-1 should be wellest Executed at 1 ☐ Yes XXNo Director Reisterstown MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 U.S.A. 319 Norqulf Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify: 3√Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Mundon Unknown traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Buckholz / Son 305 E. 24th St. 17-S; New York, N.Y. 10010 other 20b. Place of Disposition (Name of cometery, crematory or other pl Driud Ridge Cemetery 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 □Removal from State permit. Page Department of Important: If any injury or once. injury or 5 Other (Specify) 4 Donation 1/28/07 Pikesville, 21. Signature of Funeral Sovice Licenses 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 copero 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LS (1) this considerce of cordiomy of 2 th Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit been signed by the attending physicien and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 🗆 Wo 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 Yes 2 NNo Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 1 (XInpatient 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Feath Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury Natural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

filed within 72 hours after death with the Maryland

and Mental Hyglene.

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Pages 1 and 2 ment of Health a

The law requires that the death certificate be executed

After this certificate has

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To the Hospitel or Attending

death.

within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

or 28a-f show

State Registrar

DHMH 17 Rev 1/2001

DURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month TYRONE BROOKS 6:35 January 2001 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours **™** M 2□ 577 62 3707 60 8-14-1946 WASHINGTON, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD PRINCE GEORGES **GLENARDEN** 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 1418 7TH STREET 20206 14. Race - American I Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status 1 ☐ Yes AX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 【No Specify. BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) METROPOLITAN Elementary/Secondary (0-12) College (1-4or 5+) POLICE DEPARTMENT DC POLICE OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHNNY C. BROOKS, SR. DARWIN CROMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE B. BROOKS/WIFE 1418 7TH STREET, GLENARDEN, MD 20206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 □Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) HARMONY 1-30-2007 LANDOVER, MD 22. Name and Address MARSHALL'S FUNERAL HOME OF MD, INC 21. Signature of Funeral Service Licensee 4308 SUITLAND RD, SUITLAND, MD 20746 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stack, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1R culat Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 00 Non- ischemic Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2/1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed burial-transil P.O. Box 68760, physician ass attending | ed by the a Division or Vital Records, To the Hospital or Attending Physician:

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

and 2 should be filed within 72 hours after

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Media once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

filled in by the funeral within 24 hours after death.

To the Funeral Director: After

State Registrar

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Promise Dr. Bowie, MD 20720

determined

52865

2007

30. Name and address of person who complete I cause of death (Item 23a) (Type, Print)

Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JAN 29 2007

			1 - For State Registrar	State of Mary		artment of H		nd Me		ene g. No. 2 ()	07 0216	7
	Physic /Medi		1. Decedent's Name (First, Middle, Last Isabella)	Ca	mpbell			2. Date of Death Month	1	Year 9: 10 A M	
	Exami		4a. Facility Name (If not institution, give Union Memorial	street and number) Hospital		4b. City, Town, or Bal	Location of		The state of the s	4c. County of Death		
	Funeral Director		5. Social Security Number 6. Se 217–26–4685	_ 12	yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, 5-24-1	Yea <i>r)</i> 928	9. Birthplace (State or Foreign Country) S.C.	7
	anyland show d at	_	10a. State 10b. County		c. City, Town or Lo						10d. Inside City Limits	
	the Ma 28a-f	Director	Md. N	A	Ba	ltimore 10f. Zip Code			140	- 0'''	1 Yes 2 No	_
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	tems ?	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		in? (Speci Puerto Ri	ify Yes or No-	14. Race -	American Indian, White, etc.	_
5-0036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	۾	1 ☐ Never Married 2 ☐ Married ③ ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 【XNo	Specify:			Specify:	Black	
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Maryland 21	be school	To Be	Samuel	1	David			s Name (/ Jgie	First, Middle, Ma	aiden Surname) McFai		
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	1 an Heal Sm 2		Maggie Harnson 20a. Method of Disposition	Daughte 20	Ob. Place of Dispo	Shelter sition (Name of	i	Stre			Md. 21040 ty or Town, State	_
Baltimore,			1 X Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (<i>Specify</i>)	lemoval from State		natory or other place Mem. Pk.	· :	-26-		Arbutus		
Balt	permit. Page Department Important: If any injury of once.		21. Signature of Funeral Service License	112 0100		Name and Address			arch F.	H. East		٦
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Uroser	515						Approximate Interval Between Onset and Death DOULTS	Ì
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ecords, r	To the Hospital or Attending Physician: The law requires that the da within E4 brous alter death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	þ	Part ii. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause giver	n în Part i.			cco use contribu	te to the cause of death?	
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	ding P		27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work? M 1 □ Yo	at ?	28d	I. Describe how			- 1
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A building, etc. (Sp	at home, farm, stre		es 2 □ No		Location (Stree	et and Number o	or Rural Route Number,	+
3	spital oners a neral C		29a. Certifier Certifying Phys	ician: To the best of my	knowledge, death	occurred at the time	e. date and r	place, and	due to the sour	20/2) 4	or an atatad	-
	the Ho nin 24 h the Fu npletefy	Medical	one)	er: On the basis of exan and manner stated.	nination and/or inv	estigation, in my opi	inion, death	occurred	at the time, date	and place, and	due to the cause(s)	
	or viti	2	29b. Signature and title of certifier			29c. License	number		29d.	Date signed (M	fonth, Day, Year)	1
	2		30. Name and address of person who cor	mpleted cause of death (item 23a) (Tvpe. P	rint) 24	389	146)(anucry	19,2007	-
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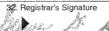
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Jean A. Czykalo p^{M} 8:00 /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 303 Maiden Choice Lane #312 Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1□M 2√2 F 213-20-6142 93 Director 10/19/1913 MΔ Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number ō 303 Maiden Choice Lane #312 21227 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene. n 27 is marked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wojciech Ziemba Agatha Mrok ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Paula J. Bullinger-Daughter 1825 Palo Circle Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition T Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Cemetery 1/29/2007 Baltimore, MD 21229 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4107 Wilkens Avenue Hubbard Funeral Home, Inc. -Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIOVASCULAR EVENT /Medical Due to (or as a consequence of): Examiner HYPERLIPINEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown ADVANCED 10E Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred spital or Attending Prous after death.
Ineral Director: After t Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 [Life-tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) JAN 2 9 2007

LAURENCE

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GALLACER, MD

allager, MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAURENCE GALLAGER, MD 716 MAIDEL CHOICE LANE, CATOUSUICE, MD 21278

D01786

JAN. 26,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2007 S:WPM Carnaggio **Physician** ovence /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Bon Secours Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 XF Yrs. Maryland 07/16/1903 212-01-2531 Director 103 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in then "netural", or items 23s or 28s-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No Ellicott City Directo MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21042 3410 Tyler Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printing Manfuacturer Label Inspector other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be far and Mental F Be ss 1 end 2 should be f of Health and Mental I I tem 27 is marked o Elizabeth McConville Harry Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Josephine M. Buckingham (Daughter) 3410 Tyler Drive, Ellicott City, Maryland 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If itel any injury or oth 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 01/31/2007 | Baltimore, Maryland New Cathedral 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 27. Signature of Euneral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Loute Myscardial Priysician /Medical Due to (or as a consequence of) **Examiner** Heart per tensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to a a consequence of) Examine The law requires that the death certificate be executed physicien and s the buriel-transit Due to (or as a consequence of) Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ğ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ፩ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 🖾 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident hours after death unerel Diractor: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier lonuary Medical House Officer pleted cause of death (Item 23a) (Type, Print) Bon Secours Hospital, 2000 Wass boltmore street, Baltimore, Maryland icardo

DHMH 17 Rev 1/2001

State

Registrar

JAN 2 9 20

2007

Carried States

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEN TITM#12 perFH C863, 1/29/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 25 **Physician** MAIMON М COHEN 2007 12:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/24/1935 Sirthplac Country) MD 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2□ F Yrs. 219-30-8178 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland attributed to Heath and Mental Hyglene. Ordant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or Items 25a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3501 WOODVALLEY DRIVE U.S.A.

14. Race - American Indian,
Black, White, etc. 21208 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ GENETICIST HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ GEDALIAH COHEN CHANA WIFNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3501 WOODVALLEY DRIVE - BALTIMORE, MD 21208 BARBARA COHEN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. FORBAND CEMETERY 01/28/2007 ROSEDALE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. MD_21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER **Physician** \circ mente ASMI disease or condition resulting in death) /Medical Due to (or as a co nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical for use as sate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 of ther (Specify) 2⊋No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier JANUARY 25, 2007 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Balto. Md Zo 201 701 6

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2

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gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JÄNUARY 27, 2007 5:55 P M CYLUS ABRA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 11702 WOODLAND DRIVE LUTHERVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country)
 N 1 7. Age (In vrs. last birthday) **Funeral** 0672171952 Months Days Hours Min 1 □ M 2 ▼ F 54 NJ Director 158-42-7884 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No LUTHERVILLE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 11702 WOODLAND DRIVE Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married 1 ∐ Yes 2 X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 WHITE "natural", or 1 ☐ Yes 2 X No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DENTAL **BOOKKEEPER** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fi lealth and Mental H m 27 is marked ot Be DOROTHY GITTLEMAN FEIN CHARLES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 11702 WOODLAND DRIVE - LUTHERVILLE, MD 21093 GRANT CYLUS / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BETH TFILOH CEMETERY 01/28/2007 WOODLAWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1/2 YRS Immediate Cause (Final disease or condition resulting in death) GLIOBLASTOMA MULTIFORME Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of The law requires that the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy certificate 2 **X** No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of ce fifie 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 27, 2007 D0012688 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

LEWIS CYLUS

31. Date filed (Month, Day, Year)

OWINGS MILLS, MD 21117

12002 RIDGE VALLEY DRIVE

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registre Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month PAULINE 40 **Physician** 24 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Center Baltimore Brightwood
5. Social Security Number Lutine + 01 1le 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\QF 218-12-8713 Yrs Feb 24, 1920 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director N/A Md Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA or Items 23a Braddish AVR 2312 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Meatle 2006. Elementary/Secondary (0-12) College (1-4or 5+) Clerk 4 Yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Reginald Blackwell Meade ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4109 Fordleigh Ad Linian Redd Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/07 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem PK 21. Signature Fureral Service License 22. Name and Address of Facility Chatman Baltimore 5240 Reisterstown Prd 23a. Part1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final dease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the buriaf-translt To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed FAILUNE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No Division of Vital npletely filled in by the funeral director, 25. Was case refe examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Mann of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of Certification: After t 5 Pending investigation 1 ☐ Yes 2 ☐ No М within 24 hours after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 032717 eledo amo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6BMC 601 GUITE 4202 FERNAND O DELGABO ME TOUSON 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 29 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #7,8, perInf, G864, 2/1/07 TT Certificate of Docth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MILDRED COHEN JANUARY 23, 2007 2:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 190 01/17/1915 7. Age (In yrs. last birthday) 1906 **Funeral** Birthplace (State or Foreign Country)
 \(\sqrt{\Lambda} \) Months Days 1 ☐ M 2 💢 F Hours 215-03-4647 92 Yrs. VΑ Director 101 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at any injury or other traumatic event; the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 💢 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 725 MT. WILSON LANE 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: 3 X Widowed 4 □ Divorced Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **SACKS** HARRY ANNE CRAMER ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 BRYNMOR COURT #205 - BALTIMORE, MD 21208 HARRIET SCHUNICK / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHAAREI TFILOH CEM. 01/26/2007 WOODLAWN, MD 22. Name and Address of Facility Signature of Funeral Service License SOL LEVINSON & BROS., INC. <u> 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NewMonio disease or condition resulting in death) weeks /Medical Due to (or as a consequence of) Examiner roke Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death Day Month Year 5 ☐ Other (specify) ed by the 9☐Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has t irector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: မှ 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury ours after death.
neral Director; A
filled in by the fu 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

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BALTMORE

MD

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32. Registrar's Signature

PAUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MESHUL

31. Date filed (Month, Day, Year)

JOEL

29d. Date signed (Month, Day, Year)

23, 2007

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Dl		1- State Registrer 1. Decedent's Name (First, Middle, L	ast)	الحا	runcate	of Death	2. Date of Dea Month	th Day Yea	3. Time of Deat
Physici /Medi		ELEANOR	DO				O/_	22 200	1 2 5 / 1
Examir		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, To	wn, or Location of Dea	th	4c. County of De	eath
. 3		1535 FLORIDA AVE.						ANNE ARUN	
Funeral Director			1 M 2 F	(In yrs. last birthday) 84 Yrs.	Months D	'ear If Under 24 Hrs ays Hours Min			Birthplace (State or For Country) MD
f show	ō	10a. State 10b. County		Oc. City, Town or Lo	ocation				10d. Inside City Lin
288	rect	10e. Street and Number	(DEL	SEVERN	10f. Zip Co	de		0g. Citizen of What	
30 01	I D	1535 FLORIDA AVE.			21144			USA	
	ner	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Deceden	t of Hispanic Origin? (Specify Yes or No-	14. Race - Ar	merican Indian,
el', or its	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 X	Cuban, Mexican, Puè K No <i>Specity:</i>	no rican, etc.)	Specify:	hite, etc. 쌍HITE
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l Health and Mental Hyglene. Item 27 is marked other then "naturel", or iteme 23e or 28a-f ehow other traumatic event, it a Medical Examinat count for colified at	To Be (17. Father's Name (First, Middle, Las	t) MARCE				rme (First, Middle, a	Maiden Sumame)	
s ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (S	treet and Number or R	Rural Route Number	r, City or Town, State	a, Zip Code)
afith a		FRANK DOOLEY	SON	1535	FLORIDA	AVE. SEVERN,	MD 21144		
ent of He nt: If itan ry or oth		20a. Method of Disposition 1 □ Burial 2XX Cremation 3 4 □ Donation 5 □ Other (Spec		20b. Place of Disponentery, cree	matory or othe	r place)	Date 24.2007	BALTIMORE,	
Department of Health a Important: If Itam 27 Is eny injury or other tra once.		21. Signature of Funeral Service Lice	nsee '\	l f	Name and A	ddress of Facility RAL HOME, P.A HWY S. GLEN	١.		rib
ysician Medical aminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	consequence of):	Bla	ddu	moras	totic	Onset and Dea
physicien and s the burial-transit	cal	that initiated events resulting in death) Last	Due to (or as a d	consequence of):					
y the attending physi ached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	□Ectopic pregr □ Other <i>(specii</i>			23d. Date of o	delivery Day Yea
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rtifice stor, p	0	25. Was case referred to medical				26. Place of De	eath (Check only on		53 2010
his ce I direk	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA	Other: 4 Nursing	Home 5 Reside	ence 6 Other (S)	pecify)
death. ctor: After th y the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigate		/ear) 28b. Time o	of 28c.	Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred	
after d Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury building, etc.	/ - At home, farm, st (Specify)	reet, factory, of	fice	28f. Location (Si City or Town		Rural Route Number,
உரை ந	Medical (29a. Certifier 1 Certifying F (Check only 2 Medical Execution)	Physician: To the best of aminer: On the basis of e and manner state	xamination and/or in	h occurred at to vestigation, in	he time, date and plac my opinion, death occ	e, and due to the curred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
n 24 hours ha Funerel sletely fille	9	001 0: 11:11-11:11:11	~-/)		29c. Li	cense number		9d. Date signed (Mo	
within 24 hours after death. To the Funerei Director: After this certificate hes completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier	Heinta	wi	í	21438		Jonua	MD2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 1,23a per dr., G863 01/29/07dhb.

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Anthony Doy **Physician** Month Day Year 6:59 PM 0 21 4a. Facility Name (If not institution, give street and number) /Medical 2007 Examiner 4b. City. Town, or Location of Death 4c. County of Death Barren Mediby Bathmore urity Number M D If Under 24 Johns County 8. Date of Birth (Month, Day, Year) 5. Social Security ge (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 220-60-9383 **№** M 2 F Months Days Hours Min 5 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD n/a Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4412 Forest View Avenue 21206 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Black 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Photographer Photography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Doy June Stewart ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Rogers Doy, wife 4412 Forest View Avenue, Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Mt. Calvary U.M.C. Jan 27, 2007 Arnold, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 22. Name and Address of Facility Miller-Dippel Funeral Home, Baltimore, Maryland 21206 Inc 6415 Belair Road, Baltimore, Maryland 23a. Part1. Enter the dise shock, or heart one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw detween tand Death Spontaneous Brainsten Hemorrhage Immediate Cau Final disease or condition resulting in death) Brainston **Physician** nemorphage /Medical Due to (or as a consequence of). Hypertension Examiner vears Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): તું કુલ Bivision or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 2Z No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 1 ☐ Yes No No မ 1) Inpatient 2 ER/Outpatient 3 DOA After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 2 □ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Funeral Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 24 within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 Gunan 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Vaidy Punit 4940 Easter

Registrar DHMH 17 Rev 1/2001

State

MD

Year

32. Registrar's Signature

31. Date filed (Month, Day,

	, i
Faith Edward-Adkinson	State of Maryland / Department of Health and Mental Hygiene
Takin Lawara / takin son	State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of D	eath	Reg No. 2007 0217
Physician/	Decedent's Name (First, Middle,Last)	ALL:	2. Date of De	ath 3. Time of Death
Medical Examiner	4a. Facility Name (if not institution, give str	-Atkinson	Month January 2 City, Town, or Location of Death	28, 2007 0100 fils 4c. County of Death
	1010 West Baltimore Street		altimore City	6//A-
Funeral	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	f Under 1 Year If Under 24Hrs. 8. Date of B	(11111111111111111111111111111111111111
Director	213-34-0273 1 M	2 X F 68 Yrs.	Months Days Hours Min.	- 1938 Foreign Country) Va.
	Usual Residence of Decedent			7,55
w any	10a. State 10b. County	10c. City, Town or Location		10d Inside City Limits
fand france.	Md N/A	Baltimor		1 X Yes 2 No
Mary r 28a ed at	10e. Street and Number	C_1	21223	10g. Citizen of What Country?
ith the notific	1010 W. Dahi	NOTE ST. . Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S	ecedent of Hispanic Origin? (Specify Yes or N	WidiA.
er death with the Maryland , or items 23a or 28a-f show any r must be notified at once. Funeral Director	1 Never Married 2 Married	Armed Forces? If Yes,	specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
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ours aft satural" xamine	15. Decedent's Education (Specify only h		Usual Occupation (Give kind of work done of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		(118.
OO3 withing sene.	17. Eather's Name (First, Middle, Last)	2 Dr	18.Mother's Name (First, Middle,	Maiden Surrame)
215. 215. pe filed ntal Hy rked of ent, by Be C		<i>1</i> c	C 1 1/ X	78eV
ID 21215-0036 should be filed within 77 and Mental Hygiene. 7 is marked other than natic event, the Me fital To Be Comple	19a Informant's Name/Relationship (Type		dress (Street and Number or Rural Route Nu	mber, City or Town, State, Zip Code)
La sa La	Filicia A. Lawren	ce 3726		. Da 100. fed, 21229
re, ME s: land 2 s of Health at If item 27 rer traums	20a. Method of Disposition 1 Burial 2 To Cremation 3	20b. Place of Disposition Removal from State crematory or other		20c. Location - City or Town, State
드스운동님	4 Donation 5 Other Specify:	Greenmount		Balto. Ad.
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traum	21. Signature of uneral Service Lisensee	Nam C Nam	and Address of acility	end Service P.A.
	23a Part I Enter the disease or complicate	has that caused the death. Do not enter the n	ode of dving such as cardiac or respiratory as	rest, shock, or heart Approximate Interval
Physician /Medical	failure. List only one cause on each I	he.	node of dying, odorrab saratable in respiratory as	Between Onset and Death
xaminer		to (or as a consequence of):		Baut
	Sequentially list conditions,	sion of hemodialysis graft		
red Insit Examiner	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of):		
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8760, inficate being physic as the bunin/Med		3c. If yes, outcome of pregnancy Live birth 2 Fetal of	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 687 ne death certific the attending p hed for use as the	past 12 months?	Pregnant at time of death 5 Other	(Specify)	10
Records, P.O. Box The law requires that the death freate has been signed by the atte page 2 should be detached for u Completed by Physic			orbitan assume sistem in Book I	
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the d ars after death al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached bertification: To Be Completed by Physician and page 2 should be detached by Physician and provided the physician and provided the physician and provided the physician and provided the physician and provided the physician and physician are provided the physician and physician and physician are provided the physician and physician are provided the physician and physician are physician and phy		ntributing to death but not resulting in the unde		tobacco use contribute to the cause of death? es 2 V No 3 Probably 4 Unknown
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Records, The law require, fricate has been sig, page 2 should by Completed			auto	
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Vital Rechysician: The labilities certificate la director, page	examiner? Hosp	ital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only one) Other Nursing Home 5	Residence 6 V Other Scene
n of \ ling Phy After th funeral on: To	27 Manner of Death	28a. Date of Injury (Month Day Year) 28b. Time of Injury	y 28c. Injury at Work? 28d. Describe	how injury occurred
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ViSi or At fifter d Direct in by	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, street, fa	actory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City
Division o spital or Attending tours after death neral Director: Aft filled in by the func Certification:	4 Homicide determined	(Specify) residence	1010 West E	Baltimore Street , Baltimore, MD
		To the best of my knowledge, death occurred the basis of examination and/or investigation		
To the Ho within 24 To the Fu completely	29b. Signature and title of certifier	d manner stated.	29c. License number	29d Date signed (Month, Day, Year)
	D+ 1).	Don.	O.C.M.E.	January 28, 2007
	30. Name and address of person who com	pleted cause of death (Item 23a)		13.134.7 25, 2007
1	Patricia Aronica-Pollak MD.	` ` ` ` ' ` ' ` ' ' ' ' ' ' ' ' ' ' ' '	11 Penn Street, Baltimore, MD 2120	01
State		32. Registrar's Signature		
Registra	JAN 2 9 20	101 Heren & dos	del.	
DHIVIT TO REV 172001		ORIGINAL	•	

Physician /Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

27 is marked other than "natural", or tema 23a or 28a-1 show traumatic event, the Modical Examiner must be notified at

Baltimore, Maryland 21215-0036

2 should be f and Mental h

permit. Peges 1 end 2 should be Depertment of Health and Menta Important: If them 27 is marked any finjury or other traumatic ev 9DGS.

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To the Hospitat within 24 hours el

or Attending Physician:

death.

filled in by

Medical

State Registrar

DHMH 17 Rev 1/2001

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

4 - Homicide

29a. Certifies

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D 41410

JUGINDER P

MUDTZPHONEN

29d. Date signed (Month, Day, Year) January 2017 MEHTA

211 33

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINTH WEST

CENTEL 32 Registrar's Signature

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Jacquetta Grant 910 anuary a M /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death General tal NA land timore tv Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Bate of Birth (Month, Day, Year) 1 □ M 2 🕸 F Hours Min. 216-52-1920 56 Director 11-21-1950 Md. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location with the Marylar 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at Director Md. NA Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [2] No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Po Maryland 21215-0036 1 ☐ Yes 2 No þ Black Specify: 3 Widowed 4 Divorced Completed the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Diaabled NA marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Achie Grant Julia 7 is marke traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2428 Greenmount Cem., Baltimore, Md. Alphonso Pittman Husband other Department of Heali Important: If Item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 1-27-07 Baltimore, Md. Greenmount Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Avenue, Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HEGHIREC 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PRator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician use as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 9□Unknown Month 5 ☐ Other (specify) P.O. | been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown cate has t 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed certificate 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral (27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural (Month, Day 5 Pending investigation death. 1∏Yes 2 No To the Hospital or Attend within 24 hours after death To the Funeral Director; 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of confifie 29d. Date signed (Month, Day, Year)

9

State Registrar 31. Date filed (Month, Day,

Year)

JAN 29

DHMH 17 Rev 1/2001

death (Item_23a) (Type, Print)

Registrar's

			1 - For Amend #17, perF	State of M H, G863, 1/2	laryland 9/07 TT	l / Depa	artment of H	ealth ar Death	nd Mental Hy	giene	007	0.0	170
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	or 28a	Director	10e. Street and Number				10f. Zip Code	01.01.4		10g. Citizen o		itry?	_
	ath wi	ral	1202 Ambridge	,				21014			USA		
920	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	?] No	1	_	spanic Origir n, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)	ľ	ace - Americ lack, White, cify: Whi	etc.	
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2	es 1 and 2 should b of Health and Ment f Item 27 is marked r other traumatic e		19a. Informant's Name/Relationship James Gyolai /	(Type. Print) Son		19b. Mailir 120	ng Address (Street a 2 Ambridg	e Roac	or Rural Route Numb 1, Bel Air	per, City or Tow MD 2	n, State, Zip 1014	Code)	
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687	tificate ig phy as the	ledic		L d									
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	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examination	on and/or in	vestigation, in my o	pinion, death	occurred at the time	, date and plac	e, and due to	ateg. the cause	(s)
	To the I	Me	29b. Signature and title of certifier				29c. License	number		29d. Date sign	ned (Month,	Day, Year)	
	23		Daniel	350			03	227	5	Janua	Fm 24	200	7
	8		30. Name and address of person who					T 4.T-	MD 0110			,	
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			For State Registrar	State of Marylar		ent of He			iene	7 02180
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	Funeral Director			77. Age (In yrs.	. last birthday) If Ur Yrs. Mont	hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB 1, 1		9. Birthplace (State or Foreign Country) GERMANY
4	h the Maryland or 28a-1 show	Director	Usual Residence of Decedent 10a. State 10b. County MD ANNE ARUN 10e. Street and Number		ity, Town or Location	7in Coda		14	Do Citizan of Mil	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
UK 50 V.	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examinat must be notified at	by Funeral	1711 SAUNDERS WAY 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:	J.S. 13. Was De If Yes,	s XX No	Specify:	pecify Yes or No- b Rican, etc.)	Black,	- American Indian, White, etc. 财HITE
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NTER Maryland 2	should be filed ad Mental Hygi marked other imatic avant, I	To Be C	17. Father's Name (First, Middle, Last) FRITZ LOBE		TIONE		18. Mother's Nam	ne (First, Middle, M		
	1 and 2 s Health ar sm 27 is ther trau		19a. Informant's Name/Relationship (7 CARLA SUE WHITE 20a. Method of Disposition	DAUGHTER 20b.		NINGSIDE	DR. GLEN	BURNIE, MD Date	21061	ity or Town, State
$(\mathcal{A}\ \mathcal{U}$ Baltimore,	permit. Pages Depertment of Important: if it any injury or o		XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signar for Funeral Service ☐ Canalism (Canalism Canalism) MD\	VETCEM CROWNS	SVILLE and Address	2.1.2		CROWNSVII	LLE MD
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			For	, iou,	State	of Ma	ryland /					and M	lental Hy	giene	-09.D10			
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	/Medic	- 1	4a. Facility Name (If	not institution,	give street and	number)			4b. City, T			of Death	7111	4c.	County of De	· ·		fm
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\$ \$ 1 430	Sta Registr		31. Date filed (Month	JAN 2	()	2. Registra	r's Signature		bortes	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 Per FH C864 2/02/0/Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Holmes 2007 Juanita 23 2346p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Good Samaritan Hospital Baltimore 8. Date of Birth 0-16-1943 rthplace (State or Foreign (Month, Day, Year) Country) N.C. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min 1 ☐ M 2 💢 F Months Days Hours 238-72-1963 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show Yes 2□No Directo Md. NA Baltimore 1055@Sand Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.
and if item 27 is marked other than "natural", or items 23a or item yor other traumatic event, the Medical Examiner must be nuy or other traumatic event, the Medical Examiner must be no 5503 Bowleys Lane Apt. 3-C 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: Completed by Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore 12th grade Office of employment Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Clifton Geneva Brown Holmes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Cain 20 W. Howe Rd., Tallmadge, Ohio 44278 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Department of Important; if any injury or once, Yabkin Grove Bapt. Ch 1 - 31 - 07Salisbury, N.C. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East la Wane 21202 1101 E. North Avenue, Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute myocardial Infarchion 4000 /Medical Due to (or as a consequence of): Examiner Coronary Date to (or as a nonsequence of) Antry Riggase 10 years Sequentially list conditions, it any, sauling to infinitely cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Slexp aprea Completed 24a. Was an autopsy performed? 1□ Yes 2★No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 043386 1,26 07 ree 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bullimore ND 2/201 Howard #405 821 ELHIN

Registrar

State

31. Date filed (Month, Day, Year)

JAN 2 9 2007

Registrar's Signature

			For State Registrar	State of M	Marylan		artment of H rtificate of L			R	eg. No.	7	02183
	Physicia	an l	Decedent's Name (First, Middle, L Decedent's Name (First, Middle, Middle, L Decedent's Name (First, Middle,	ast)	U.	icks			2	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Ann	to steed and sumbo		ICKS	4b. City, Town, or	Logation of	Dogth	01	4c. County	OO'7	17:30 PM
10.	Examin	er	4a. Facility Name (If not institution, g		SPETA	N)	BALT			13	NA NA		
	Funeral			Cau 7		last birthday)	If Under 1 Year	If Under 24	4 Hrs.	B. Date of Birth	Vaarl	9. Birth	place (State or Foreign
	Director		220-12-5044	1□ M 2☐ F	87	Yrs.	Months Days	Hours	Min.	(Mogth, 23)	-1919	COU	Va.
	pu 🛦		Usual Residence of Decedent 10a, State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Aaryla f eho	ō	Md. NA	Δ		Balti							X□Yes 2□No
	the 28a-	rect	10e. Street and Number	•		20101	10f. Zip Code			1	0g. Citizen of V	Vhat Cou	ntry?
	h with	D E	401 E. 25th Str	eet Apt.	3-н		21218	3			USA		
	ems a	ner	11. Marital Status	12. Was Deceder	nt Ever in U.	.S. 13.	Was Decedent of H Il Yes, specify Cuba	ispanic Origi n, Mexican,	in? (Spec Puerto R	fy Yes or No- ican, etc.)		e - Ameri	can Indian, etc.
36	or it	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 □ Yes 2 [If Yes, Give Year or Date			1 ☐ Yes 2 📉 No	Specify:			Specify	· B]	lack
21215-0036	72 hours after death with the Maryland natural, or items 23s or 28s f ehow dical Examinar must be notified at	ed b	15. Decedent's		s.	16a. Dece	dent's Usual Occup	ation			16b, Kind of Br		
215	nin 72 In "ne Medic	plet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4c	or 5+1	(Give	kind of work done of DO NOT use retired	durina most d	of working	g			·
212	filed within Hygiene. Phygiene. pther then "rent, the Med	Completed	10th grade	Conege (1-40		Hon	nemaker				Own He		
Maryland	2 should be file and Mental Hy le marked oth aumatic event	To Be (17. Father's Name (First, Middle, Las Frank	Cart	er				's Name (Maiden Suman Wa	atsor	ı
Mary	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene I Health and Mental Hygiene I Health and Mental Hygiene I nativest, or Items 23s or 28s-f show item 27 Is marked other then "natural", or Items 23s or 28s-f show other traumatic event, The Medical Examinar must be notified at		19a. Informant's Name/Relationship Mary Lois Smith		ster		ng Address <i>(Street :</i> 3—15 234t)						o Code) L422
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Ite		20a. Method of Disposition 1		. 0	emetery, crei	osition (Name of matory or other place Cemeter	ee) У	Da 1-25		20c. Location - Burkes	•	
Balti	permit. Departm Imports eny inju		21. Signature of Funeral Service Lic	onsee What re	m)		2. Name and Addres	•			.H. East ore, Md	_	L202
			23a. Pr. Enter the disease, or conhuck, or heart failure. List on	mplications that cause on each	sed the deat	h. Do not en	ter the mode of dyin	g, such as c	ardiac or	respiratory arr	est,		Approximate Interval Between
ja.	Pnysician		Im enate Cause (Final di ense or condition			-	SHOC	Н				l	Onset and Death
	/Medical Examiner		resulting in death)		as a conseq								
		-	Sequentially list conditions,	b. Due to (or	as a conseq	uence of):						-	
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events		,								
, O	sate be executed obysicien end the burial-transit	Еха	resulting in death) Last	C. Due to (or	as a conseq	uence of):							
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9	entifica ling ph e as th	Med	IF FEMALE:										
Box	The law requires that the death certificate be executed ete has been signed by the attending physicien end page 2 should be deteched for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1⊟Live birth 4⊟Pregnant	2 ☐ Feta	Ideath 3	☐Ectopic pregnancy ☐ Other (specify)					te of deliv nth	ery Day Year
o.	the de y the iched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr									
σ.	res that the de signed by the a be detached f	by Pt	Part II. Other significant conditions	contributing to death	h but not res	utting in the u	inderlying cause giv	en in Part I.		23e. Did to	bacco use cont	ribute to t	the cause of death?
rds	w require been sig should b	ed b	DIMENT	IA						1 🗆 Y	es 2 DMG	3 ☐ Pro	bably 4 Unknown
Records,	e law requ has been je 2 shoul	Completed	DIABET	BS MB	LLI	TUS				24a. Was a	an 24b.	Were auto	opsy lindings available ompletion of cause of
<u>m</u>	The page	Com								perfor	med?	death?	2□ No
Vital	ician: The	Be	25. Was case referred to medical examiner?	Hospital:			104		ol Death	(Check only or	10)		
of	shys this al did	٠ <u>۲</u>	1 Yes 2 No	1 = inp		ER/Outpatie 28b. Time o		4 🗆 Nuli			ence 6 Oth		fy)
O	ding F. After fune	tion	1 Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	Injury	Wor	k?" Yes 2 □ N		od. Describe ii	ow anjury occur		
Division	Attendi	ifica	3 Suicide 6 Could not	be 28e. Place of	Injury - At h	ome, larm, st	reet, factory, office					er or Rur	al Route Number,
Ę	el or safter	Certification:	4 Homicide	building,	etc. (Specil	(y)				City or Tow	n, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	Medicai (29a. Certifier 1 Certifying (Check only one)	Physician: To the be aminer: On the basis and manner	s of examina	owledge, deat ation and/or in	th occurred at the tine evestigation, in my o	ne, date and pinion, death	l place, ar h occurre	nd due to the d d at the time, d	ause(s) and ma date and place,	anner as a	stated. to the cause(s)
	To the To the To the Comp	Me	29b. Signature and title of certifier	*	-		29c. Licens				29d. Date signe	1	
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	6		30. Name and address of person wh										
	7			BRANT,	5601	LOCA	+ RAUSI	N BLI	D.	BALT	MORB	M	021239.
	Sta Registi		31. Date liled (Month Pay, Year)	2007	15. L	ature	and s						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Alice Wilhelmina Horsford 2007 8:25p M January 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/27/1914 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□M 2√2F 580-03-3496 92 Yrs Director VT Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notifled at MD Montgomery Germantown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death with 20331 Cedarhurst Way 20876 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ö 1 ☐ Yes 2 ☐ No Specify. <u>ک</u> Black Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l other than vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) Custodian Worker Public Works unkn. 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ဥ 19a. Informant's Name/Relationship (Type. Print) Charlene Daniel / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20331 Cedarhurst Way, Germantown, MD 20876 Health em 27 Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State to = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 2/2/2007 Department of Important: If any injury or once, Kingshill Cemetery Kingshill, VI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Address of Facility L. Fort Avenue, Baltimore, MD 21230 NUNS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Live /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans a resulting in death) Last Due to (or as Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ♣ No 24a. Was an page 2 s autopsy perform certificate 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certific

31. Date filed (Month, Day,

30. Name and address of person who

Baltimore, Maryland 21215-0036

P.O. Box 68760,

or Vital Records,

Division

Mco

and manner stated.

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Beatrice Elena Hagel State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 23, 2007 Elena Medical Examiner Hagel Beatrice 1040 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 625 Hubner Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. **Funeral** Foreign El Salvadore Director 54 Months Days Hours Min. 139-38-1480 9-5-1952 1 M 2 X F Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 X Yes 2 No items 23a or 28a-f shoust be no iffed at once. Md. NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21211 USA 625 Huber Street Apt. A Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 White etc Married Yes item 27 is marked other than "natural", traumatic event, the Medical Examiner Widowed 4 Divorced If Yes. Give Year Yes 2 X No specify: Specify White \$ permit Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Disabled 12th grade l yr. NA 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Hagel Regina Gallegos Joseph Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co \$141 1865 79th Street Causeway #7G, N. Bay Village, Fl. 19a. Informant's Name/Relationship (Type, Print) nt: If item 27 is n other traumatic Cecilia Pinal Sister 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Important: injury or ot Greenmount Cem. 1-26-07 Baltimore, Md. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 l adl 1101 E. North Avenue, Baltimore, Md. 23a. Part I. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Atherosclerotic cardiovascular disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical X UNPENDED attending physician or use as the burial -AMENDED #23a,PII,27,perME, g863, 1/31/07 TT Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth signed by the attending be detached for use as Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ⋧ σ. Schizophrenia 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has page 2 performed? death? Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 ER/Outpatient 3 DOA Residence 6 V Other: Scene 1 ✓ Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No hours after death. To the Funeral Director; completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) MO O.C.M.E. January 24, 2007 30. Name and address of person who completed cause of death (Item 23a)

State 31. Date filed (Month, Day, Year) 32. Regionar's Signature Registrar 1AN 2 0 2007

Tasha Greenberg MD.

DHMH 17 Rev 1/2001

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

07-00701

hristopher Hartw	1-	For State	e of iviaryland /		ficate of		IU MICITIC	ai i iygic	Reg.	No 🥎	001	7 00194
Physician	1/ 1	Decedent's Name (First, Middle,La			Hartwe	N11			ate of Death onth [nuary 25,)ay	Year	3. Time of Death 0720 hrs
Medical Examin		Christoph a. Facility Name (if not institution, g				o. City, Town, or	r Location of		riuary 25,	4c. Cour	nty of Death	
		1637 Warwick Avenue			hidi da A	Baltimore If Under 1 Yes	ar If Under	24Hrs 8	Date of Birth		NA NA Birt	hplace (State or
Funeral Director	2	219-37-3016	Sex 7. Ag	e (In yrs. last	Yrs	Months Day	_	1.0	3-26-1	,	Foreig	
any	_	Jsual Residence of Decedent Oa. State 10b. County		10c. City, To	own or Location	n		 -				10d Inside City Limits 1 X Yes 2 No
Maryland 28a-f show datonce.	١٥	Md.	NA	Ва	altimo	10f, Zip Code			100	Citizen of	What Cour	
ith the Maryland 23a or 28a-f sho notified at once.	Director	0e. Street and Number 1637 N. Warwic	k Avenue			212	16				USA	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tren of Health and Mental Hygiene nn: If item 27 is marked other than "natural", or items 23a or 28a-f she conher traumatic event, the Medical Examiner must be notified at once	ᇛ	11. Marital Status 1 X Never Married 2 Marri	12. Was Decedent	>	13. Was	Decedent of H	ispanic Origii an, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)		ace - Ameri Vhite, etc.	can Indian, Black,
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136 hin 72 h e than "r edical E	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or	5+)	Unemp	oloyed				N	A	
5-00 lled wit Hygien I other		17. Father's Name (First, Middle, La		twell	Tre		l .	s Name (Firs	t, Middle, Mari			ierce
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	o Be	Allen 19a. Informant's Name/Relationship		.cweii	19b. Mailing	Address (Stre	eet and Numb	ber or Rural	Route Numb	er, City or	Town, State	, Zıp Code)
MD id 2 sho lith and m 27 is		Jeanette Selle	rs Soc. Wo			E. Bidd		., Ba.				Town, State
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumatinjury or other traumati		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S	tate cre	ematory or oth	er place)	ometer y,	2-1-0				own, Md.
nit. Pagartmeni oortant	-	4 Donation 5 Other Spec 21. Signature of Funeral Service Lie		1 KI	22. N	ame and Addre	-	Mai	rch F.	H. Ea	st	
		23a. Part I. Enter the disease, or co	W a	d the death [101 E. I						21202 Approximate Interval
Physician Medical		failure. List only one cause or	a. Hyperelyce									Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	sequence of):	to prop	anic ani		0011				
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of)	:							
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60, ate be ex hysician	ledic	X UNPENDED IF FEMALE:	#23a, 27,			23/07 TT				23d. Da	ite of deliver	у
68760, ertificate be executed iding physician and	ian/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth	at time of dea	2 F6		3 Ectopio	c pregnancy		Mor	nth	Day Year
Box e death the arte	Physician/Medical	1 Yes 2 No 9 Unkn	own 9 Unknown	mantale - age	3 0	her (Specify)						the second death?
cords, P.O. Box 68760, law requires that the death entificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	by Pt	Part II. Other significant condition	ns contributing to dea	ath but not re	sulting in the	underlying caus	e given in Pa	art I.			o 3 Pro	the cause of death? bably 4 Unknown
ds, Fequires								_	24a. Was a			utopsy findings available completion of cause of
Recor The law 1 icate has b	Completed				· · · · · · · · · · · · · · · · · · ·		_			med?	death?	·
Vital R. ysician: T his certifica	Be	25. Was case referred to medical examiner?	Hospital: 1 Inna				Other	(Check only Nursing H		Dasidanas	6 🗸 Othe	ar Coopa
n of Vital Rec ding Physician: The After this certificate funeral director, page	မ	1 Yes 2 No 27. Manner of Death	28a Date of Ir (Month, Day		ER/Outpatien 28b. Time of		njury at Work		d. Describe t			er acene
ion c tending eath tor: Af	ation	1 X Natural 5 Pendi 2 Accident Invest	ng igation	i		-	Yes 2	1				
Division of Vital Records, P.O piral or Attending Physician: The law requires that to ours after death. After this certificate has been signed by filled in by the funeral director, page 2 should be detac	Certification:	3 Suicide 6 Could	not be 28e Place of	Injury - At ho	me, farm, stre	eet, factory, offic	ce building, et	tc. 28	f. Location (\$ or Town, S		Number ör R	tural Route Number, City
Hospi 24 hou Funer tely fil		4 Homicide 29a Certifier 1 Certifying Ph one) 2 Medical Exam	ysician: To the best of niner:On the basis of e	xamination ar	ge, death occu	urred at the time ation, in my opin	e, date and plantion, death or	ace, and du ccurred at th	e to the caus e time, date	se(s) and m and place,	anner as sta and due to t	ated. the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier	and manner state	d			ense number					onth, Day, Year)
		Ne lina Bra	ssell Mi	5		0.	C.M.E.			Januar	ry 25, 200	J/
		30. Name and address of person Melissa Brassell, MD	who completed cause of Assistant Medic			Penn Street	t, Baltimor	e, MD 21	201			
	tate	31. Date filed (Month, Day, Year)	4	trar's Signatu	ire	,						
Regis	trar	JAN 2 9 200	1 Residence		9					_		

		State of State of State of Registrer	Ce	rtificate of Dea		ney. No	200/	0218
Physic	ian	Decedent's Name (First, Middle, Last)			2. Dat Mo	e of Death nth Da	y Year	3. Time of Death
/Medi		KATHLEEN IRENE HOLDER		T		ARY 25, 2		0630 A
Exami	ner	4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or Locat	lion of Death	230	. County of Deat	h
		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	ROCKVILLE If Under 1 Year If Ur	nder 24 Hrs. 8 Dat	e of Birth	ONTGOMERY	hplace (State or Foreig
Funeral Director		137.52.8924	93 Yrs.	Months Days Hou	ırs Min. (Mo	nth, Day, Year) 1/1913	Co	UYANA
10% 100		Usual Residence of Decedent	33			1/191)		
ylan		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limi
the Marylan 28a-f ehow	ctor	MD MONTGOMERY	GAITHERSEU	RG				XX Yes 2 N
or 28	Director	10e. Street and Number		10f. Zip Code		10g. Cit	tizen of What Co	untry?
23a		459 STERM HEELER COURT		20877			USA	
hours after death with the Maryland turst', or items 23s or 28s-1 show I Examiner runt be nutities	Funerai	Armed For	rces2	Was Decedent of Hispanic If Yes, specify Cuban, Me:	c Origin? (Specify Ye xican, Puerto Rican, e	s or No-	14. Race - Ame Black, White	
or i	by Fu	1 Never Married 2 Married 1 Yes	2 No	1 ☐ Yes 2XX No Spe	ocify:		Specify:	
ural'	d b	3 Widowed 4 Divorced Year or Da		1-4-10-10-10-10-10-10-10-10-10-10-10-10-10-		1401-16	BLA	
within 72 ene. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	most of working	160. K	(ind of Business/	Industry
Wilh Bne.	mc	Elementary/Secondary (0-12) College (1-	-4or 5+)	SE KEEPING			HOSP I TAL	
Hygi Hygi ent.		17. Father's Name (First, Middle, Last)	1100		fother's Name (First,			
집필요	To Be	JOSEPH HARRIS		1	ILLIAN WATSO	N.		
should nd Men marke umatic	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Nu			or Town, State, Z	Zip Code)
Ith ar	1	FAYE BOBB-SEMPLE		STERNWHEELER CO				,
Hea Hea tem		20a. Method of Disposition	20b. Place of Dispe	osition (Name of	Date		ocation - City or	Town, State
Pages nent of int: If it iry or o		XX Burial 2 ☐ Cremation 3XX Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	State	matory or other place)	 EER 1 200	7	INDEN ALL	
rmit. P poartme poortan y injur Ce.		21. Signature Fun rat Signature Violense	ROSEHILL C	EMETERY 2. Name and Address of F	FEB 1, 200	L	INDEN, NJ	
permit. Pages Department of th Important: If ite eny injury or of	1 3	K. GRECORY FINK	F	INK FUNERAL HOM 26 CRAIN HWY SW	E, P.A.	, MD 2106	61	
		23a. Part Enter the disease, or con plications that ca shock or heart failure. List only one cause on ea	aused the death. Do not en ach line.	ter the mode of dying, such	h as cardiac or respir	atory arrest,		Approximate Interval Between
Physician		Immediate dause (Final disease or condition	DEMENT I A-ENI					Onset and Death 1 YRS.
/Medical		resulting in death)	or as a consequence of):	O I I I I				i ino.
Examiner		Sequentially list conditions						
D #	ner	Sequentially list conditions, Tary, leading to ammodate cause. Enter Underlying Cause (Disease or injury	or as a consequence of):					
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oe ex		Due to (c	or as a consequence of):					
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oatl for	ysic	1 Yes 2 No 9 Unknow XX		Other (specify)				
he death certifi the ettending I thed for use as	-				Part 23	e. Did tobacco i	use contribute to	the cause of death?
inat the death	4	Part II. Other significant conditions contributing to de	iarn dur not resulting in the L	inderlying cause given in P				
es that the igned by th be detache	1 by Ph	Part II. Other significant conditions contributing to de TRANSIENT ISCHEMIC ATTACK		underlying cause given in P		1□Yes 2	□No 3□Pr	
requires that the leen signed by th hould be detache	eted by Ph	TRANSIENT ISCHEMIC ATTACK		underlying cause given in P		-	□No 3□Pro	obably 4 X Unknow
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I he law requires that the ate has been signed by th page 2 should be detache	Completed by Physician/Me	TRANSIENT ISCHEMIC ATTACK		inderlying cause given in P	24	a. Was an	24b. Were au prior to death?	obably 4 X Inknov
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- state Amend #26 perMD, G863, 1/29/07 TT Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23:50 PM natherine 25 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HIMOY C If Under 24 Hrs. 8. Date of Birth (Month, Day, Hopkins Bayview Medical Center Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F Yrs. 86 Apr 19, 1920 218-09-5155 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Marylar and Mental Hygiene. I show so and or other than "natural", or Items 23a or 28a-f show unatte event, the Medical Examiner must be notified at unatte event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Md. Baltimore Eastwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7147 East Baltimore Street 21224 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8 t h College (1-4or 5+) Beautician Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked John Appel Barbara Ann Desell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once. Barbara A. Hyland/Daughter 1001 Running Creek Way Unit C Bel Air, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation Cother (Space) COMDMent Sacred Heart of Jesus Jan30,2007 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses sollac 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician liabe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the conditions of the conditions of the case. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ne attending physician and for use as the burial-tran resulting in death) Last as a consequence of) Division or Vital Records, P.O. Box 68760, non-yroidi d Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown DOVESIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Physiclan: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ope) Other: 4 Nursing Home 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier M.P 0 005517 107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brenne 3023 Eastern 21224 JO HOW

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** othnson IAMES ANUMPY 23 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandall Staun
If Under 1 Year | If Under 24 Hrs. | 8. HOSPITAL 6. Sex Baltimore Vorthwest 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) 07.04.1946 Nanyland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2 □ F 216-44-5919 Usual Residence of Decedent 60 Yrs. Director the Maryland 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location ui Hygiene. i other then "neturel", or llems 23s or 28e-f ehov vent, the Medical Exame ar must be multified at 1)X Yes 2 □ No Baltimore Directo MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1600 East Belvedere Ave. Funeral Pages 1 end 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 MaYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) abover Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ပ James Johnson, Br Edithy Tosage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date

Double Control of City or Town, State if Health if tem 27 i Margaretta Johnson/wife 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o importent: if eny injury or once. Garrigan Forest on Forest 01.30.2007 Cuines Wills IND
22. Name and Address of Facility Voughn C. Greek Juneral Service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8729 Liberty Road Thandall stam MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to imminestate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ≥ ER/Outpatient 3 DOA ို 1 Inpatient within 24 hours efter death.
To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, data and place, and due to the causa(e) and it as not as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

Old C. Kd. Kandi MyDwn MD

and Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

2007

De Lama Harlan

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend items 20b.c per in 854 2-1-07 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician anuary 24, 2007 4c. County of Death ames /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner - Dulaney Valley 7. Age (In yrs. last birthday) Baetmore limonium Maris If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours 12 M 2□ F 212-60-3375 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 Pres 2 No **Funeral Director** Mai a imo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA 21 14. Race - American Indian, Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or Items in Important: If Item 27 Is marked other than your jujury or other traumatic event, the Medica Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BWI Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AIRPORT 12-th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ones ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Balto, md. Barbara WIFE 713 Jones thnal JANUARY 20b. Pleas of Disposition (Name place) Date 20c. Louinos it Mir I sn, State 20a. Method of Disposition Pages 1 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Livenses Name and Address of Facility 70 FREDHILT Funeral Home Brito, md. 21229 Approximate Interval Between Onset and Death 23a. Part / Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate se (Final disease or condition Physician METASTATIC CANCER UNKNOWN PRIMARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if dry, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, the attending physician IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year JONES 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Certification: To Be Completed by 2 🗆 No 3 Probably 1 Tes 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2**X** No certificate 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death. death. 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) nd manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TARIQ MAHMOOD 31. Date filed (Month, Day, Year) State JAN 29 Registrar

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)		235 Carey Avenue	10.0			Salisbury			Wicomico	
Funeral Director		5. Social Security Number 147.80.7852 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last bi	rthday) Yrs.	Months Day		Min. OCT. 5	th(MM/DD/YYYY) 9. B Fore C	
v any		10a. State 10b. County		10c. City, Town	n or Location	1				10d. Inside City Limits
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Division of Vital Records, P.O. Box 68760, voitin 14 Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/	past 12 months? 1 Yes 2 No 9 V Un	4 Pregnant a	t time of death	5 Othe	I death 3		pregnancy	Month	Day Year
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09			Assistant Medical E	xaminer 1		Street, Bal	timore, M	D 21201		
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Los	K				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 20 Au /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bay-A 7. Age (In yrs. ast birthday) ear If Under 24 Hrs. Naslev 5. Social Security Number 6. Sex If Under 1 Birthplace (State or Foreign
 Country) **Funeral** Days Hours Months 1□M 2☐F 220-22-2478 95 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits other then "netural", or iteme 23a or 28a-f ehov vent, the Mydical Examin et must be notified at 1 ☑Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2634 132r 21205 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 610420 Department of Heelth and Mental Hy Important: If Item 27 is marked oth eny injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Charles Ci 19a. Informant's Name/Relationship Type, Printy Rup 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) Balk niece fimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bullinone Cem permit. 21. Signature of Funeral Service License Culluk 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Huy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): anding physicien and use as the burial-transit Due to (or as a consequence of): IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy ğ Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by this certificate has been sirel director, page 2 should I 1 Yes 2 No 3 Probably 4 Noknown 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funerel Director; Al completely filled in by the fu death. 1 TYes 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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Bulto, Mil

			state Amend #17, pe	State of rFH, g863, 1	Maryland /29/07 TI	d / Depa ^T <i>Cei</i>	artment rtificate	of H	ealth a Death	ınd M	ental Hyg	giene Reg. No	007	02193	
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Baltimore,	permit. Page Depertment Importent: If any Injury or ance.		21. Signature of Funeral Service	Licensee	0.0		2. Name an				eall Fur				
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Division of Vital Records,	Attending Physician: The law requires that the death certifica r death. ector: Atter this certificate has been signed by the ettending phe by the funeral director, page 2 should be detached for use as it.	Ö	27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date of (Mont	of Injury th, Day Year)	28b. Time o Injury		8c. Injun Wor			28d. Describe I	now injury	occurred		
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DHMH 17 Rev 1/2001

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<u> </u>	nue	11. Marital Status	Armed Fo		13. Was Dece If Yes, spe	edent of Hispanic Origin ecify Cuban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	lo- 14	Race - Ame Black, White	
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	ted	15. Deceden	nt's Education est grade completed)	16	ia. Decedent's Usu	ial Occupation	working	16b. Kind	of Business/	Industry
	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)	์เตียง ก็ก็กับกับ Machine	ork done during most of ise retired) Operato		Wort	orn F	Electric
		9th 17. Father's Name (<i>First, Middle,</i>	(unk)			t	Name (First, Midd			
	m	17. Tablet 3 Name (7 not, mode),	Last, (GITK)			10. Mother 3	rame (1 msi, 14mou	e, waiden oc	mame) (C	ilik)
	ှင် -	19a. Informant's Name/Relations	ship (Type. Print)	19	9b. Mailing Address	s (Street and Number o	r Rural Route Nurr	ber, City or T	own, State, Z	Zip Code)
	Н	Jerry Kowalc	zik/son	24	400 Gra	ble Court	Forest	Hill	,Md.	21050
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Removal from	comet	of Disposition (Na tery, crematory or	me of other place)	Date	20c. Loca	tion - City or	Town, State
		4 Donation 5 Other (S				of Jesusl-		Balt	imore,	Maryland
any injury once,		21. Signature of Funeral Service	Licensee	LX	22. Name a 1201	nd Address of FacilityK Dundalk A	aczorow ve. Bal	ski F timor	unera e, Md	1 Home
		23a. Part1. Enter the disease, shock, or heart failure. List	complications that conly one cause on e	caused the death. Do	not enter the mo	de of dying, such as car	diac or respiratory	arrest,		Approximate Interval Betwee
an	Ì	Immediate Cause (Final disease or condition resulting in death)		EART F.						Onset and Dea
al er		resulting in death)		(or as a consequence	e of):					
	.			W. M. Oak A Qu		Δ				
-	<u>a</u>	Sequentially list conditions,	D.	Or as a consuguino	EDEMI	4				
	amine	cause. Enter Underlying Cause (Disease or injury that initiated events	C. CH	(nresecuneuquinos RONIC OBS	EDENI STRUCTIV	E PULMON	iaby Di	SEASE		
	I Examine	cause. Enter Underlying Cause (Disease or injury	C. CH	(or as a consequence	EDENI STRUCTIV		iary Di	SEASH		
	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C. CH	(nresecuneuquinos RONIC OBS	EDENI STRUCTIV		iary Di	SEASE	2	
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lled in by the funeral director, page 2 should be detached for use as the bur	Certification: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Due to	tcome pf pregnancy pirth 2 Fetal dear nant at time of death own eath but not resulting th, Day Year) a finjury - At home, ling, etc. (Specify) be best of my knowledges of examination and stated.	EDENIE STRVL TIV e of): th 3 Ectopicp 5 Other (s) in the underlying of Injury M farm, street, factor ge, death occurred and/or investigation	regnancy pecify) 26. Place of OA Other: 4 Nursin 28c. Injury at Work? 1 Yes 2 No y, office d at the time, date and p, in my opinion, death c. License number	23e. Did 1	la tobacco use Yes 2 Is an opsy formed 2 No one) sidence 6 a how injury of (Street and fine) own, State e cause(s) are, date and pine 29d. Date s	d. Date of deliment of the following states of the fol	the cause of death obably 4 Donkr atopsy findings avail completion of cause 2 □ No cify) wal Route Number, a stated. to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 03 A **Physician** long ARRY LUCAS ale. 2007 Anuary /Medical 4a. Facility Name (If not institution, give street and number)

South Richey Hospice

5. Social Security Number 6. Sex 7. Ag 4c. County of Death 4b. City, Town, or Location of Death Examiner NA BAHIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign MARY) And 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M M 2□F 213-54-0955 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State th and Mentel Hygiene. 27 is marked other then "neturel", or items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at BAITIMORE 1 Yes 2 No MARYlAnd Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA weet 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 □ No 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: AMERICAN ል ICAN 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN Business 1316 Improvement 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f Yauline Jones Otha Lucas SK. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Depertment of Heelth an important; if item 27 is meny highly or other any highly or other. 3333 KERRY Road - Woodhaw MANIAND 207 SISTER Uhn5on heila Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) butus Memoriae Gra Gebiuary 3,3007 Petrokus, Marylano me funeral service 22, Name and Address of Facility 21. Signature of Funeral Service License way mound acure 3405 W. FRANKLIN St. BAHMORE, MARGAND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer IVEV **Physician** Metastatic year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. certificete has been signed by the irrector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል Records, 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 210 No 1 ☐ Yes Vital After this certifice funeral director, r 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Wether (Specify) Certification; To 1 ☐ Yes 2 Ø No ð 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö within 24 hours e To the Funerel Completely filled To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier SOM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore tospice 838 N. Eutaw St

DHMH 17 Rev 1/2001

State Registrar 50

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ٧. Ollie Little 4:00 Janvary 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year 8-2-1925 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 NT C **Funeral** 1□M 2\ F Months Days Hours Min 216-30-8495 81 N.C. Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Director NA Baltimore 1 X Yes 2 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with tal Hygiene. other than "natural", or items 23a or 2 USA 21206 4212 Seidel Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cleaners Elementary/Secondary (0-12) College (1-4or 5+) the Hav It Done Right Sorter llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be lealth and Mental and Mental Cecil Manson purvis Lucy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 is any Injury or other trau 21206 4916 Anntana Avenue, Baltimore, Md. Demetris Parren Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Trinity Cem. 1-26-07 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Md. 21. Signature of Funeral Service Licensee March F.H. East 22. Name and Address of Facility 21202 Wane 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepais Zweeks /Medical Due to (or a a consequence of) Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause before a displaying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Congestive beort to lure

Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à cate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' After this certificate Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Hospital: Other: 1 Yes 2 No 1 Inpatient မှ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. Certification: 1 Natural (Month, Day Year) 5 Pending 2 Accident investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 9 2007

> Union Memorial Hospita 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Scar Thomas Lowman P^{M} 01/25/2007 5:48 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 227 Asbury Road Anne Arundel Pasadena If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/13/1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 213-26-5629 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
Int: If item 27 is marked other than "netural", or items 23a or 28a-f show mix: If item 27 is marked other than "netural", or items 23a or 28a-f show any or other traumatic event, the Medicel Examiner must be notified at any or other traumatic event, the Medicel Examiner must be notified at 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 227 Asbury Road 21122 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 mg Yes 2 □ No 1951 — If Yes, Give Year or Dates: 1953 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Gasoline Tanker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Marshall Lowman Sophie Catherine Smith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
eny injury or other trau Dorothy Lowman / Wife 227 Asbury Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Glen Haven Mem Pk 01/29/07 Glen Burnie, MD 21. Signature of Faneral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIN 5 would /Medical Due to (or as a consequence of): Examiner neny LZHEIMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the sahould be detached by 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSUNS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 28 No 24a, Was an autopsy performed BRIL LATION 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Action 6 Other (Specify) Hospital: 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ nous after death.

neral Director: After this
filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar 29a Certifier

29b. Signature and title of certifier

Michae 31. Date filed (Month, Day, Year)

Medical

and manner stated.

32 Registrar's Signature

30. Name and address of person who completed cause of death (bem 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

100021703

Speciel wood ed St 1

29d. Date signed (Month, Day, Year)

200%

		,	1 - State Registrar	State of Marylan			nt of Health		ntal Hy	giene Reg. N6	2007	02198
200		Ť.	Decedent's Name (First, Middle, Last)						. Date of D	eath		3. Time of Death
	Physici		Willie	James	/_	20	204		Month 0	Z 6	2007	01:45 AM
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. Git	y, Town, or Location				County of Death	
		A P	Brecc	7 800 /10 400	la a é la imba da l		· /		Date of Bi	db.	, , , ,	plane (State or English
	Funeral Director		237-46-0162 6. Security Number	7. Age (In yrs. 73	Yrs.	Month		Min.	Month, D	av Vaarl	33	place (State or Foreign intry)
	Du &		Usual Residence of Decedent 10a, State 10b, County	10c. City	y, Town or Lo	cation						10d. Inside City Limits
	aryla sho	5	44.									1 ☐ Yes 2 No
	289-f	ect	Md Baltimo	re 110	seda		Ip Code			10g. Cit	izen of What Cou	intry?
	with	ă	6040 Brestow	BJ 42			212010				USA	,
	na 23	era	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Dec	edent of Hispanic Opecify Cuban, Mexico	rigin? (Speci	fy Yes or N	0-	14. Race - Ameri	
စ္တ	be filed within 72 hours after deeth with the Maryland ital Hygiene. id other then "natural", or itams 23s or 28e-1 show event, the Medical Exercians from the notified at	by Funeral Director	1 Never Married 2 ☐ Married	Amed Forces? 1 NYes 2 □ No ff Yes, Give			ecify Cuban, Mexica 2 No Specifi		can, etc.)		Black, White	etc.
21215-0036	ural',	Q D	3 Widowed 4 Divorced	Year or Dates:	10- D	-tt	10			105 16		
<u>7</u>	nati	Completed	15. Decedent's Edu (Specify only highest grade		(Give	kind of v	sual Occupation vork done during mo iuse retired)	ost of working	, .	16b. K	ind of Business/Ir	ndustry
12	withir sne.	du	Elementary/Secondary (0-12)	College (1-4or 5+)			worker		1	102	theun	.100
S	Hygie Hygie ther int,		17. Father's Name (First, Middle, Last)		0,6	21		her's Name (First, Middle	e, Maiden	Sumame)	77-1
Maryland	uld be Aental rkad o tic eve	o Be	7				9	cia P) row	~		
\geq	s 1 and 2 should I t Health and Men- Item 27 Is marks other traumatic	ဥ	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Maili	na Addre	ss (Street and Numi				or Town, State, Zi	p Code)
<u>≅</u>	nd 2 s lith ar 27 le r frau		Gregory Leavy		716	0.	pfriend	010	baltin			1220
တ်	1 and Health Iem 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (A	ame of	Dat			ocation - City or T	
Baltimore	m O		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	emetery, crei	matory o	r other place)	2/1/	07	1	. N	112
Έ	교원들 .		21. Signature of Experal Service License		5WN5V	1 / Q. 2. Name	and Address of Fac	Hity Che	atma	N- Ho	acci S Fu	Neral Home
Ba	Depa Impo sny i		18 STA	m.		240					timore	Md 21215
	_		23a. Parti. Epter the disease, or compl	ications that caused the deat							viinore	Approximate fnterval Between
	Physician /Medical Examiner	ner	shock or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to induction cause. Enter Underlying			h'c	pros.	tote	Co	nce		Onset and Death
8. 609.8	ate be executed hysicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
9	ertific ling p	0	IF FEMALE:	0-16								
О. Вох	at the death certifice by the ettending phateched for use as to	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	⊒Ectopic ⊒ Other	pregnancy (specify)				23d. Date of defiv Month	very Day Year
s, P.	es that the igned by be detacted	by Ph	Part fl. Other significant conditions con	ntnbuting to death but not res	ulting in the u	inderlying	g cause given in Par	t 1.	23e. Did	tobacco		the cause of death?
rd G	w require been si								1 🗆	Yes 2	@No 3□Pro	bably 4 Unknown
of Vital Record	The taw requires that the ate has been signed by the page 2 should be detache	Completed			-				per	opsy formed?	prior to co	opsy findings available ompfetion of cause of
ta		0	25. Was case referred to medical				26 Pia	ce of Death (1 ☐ Yes Check only	2 ANO	1 105	25 140
5	Physicien: this certific ral director,	O B	eyaminer?	Hospital:	ER/Outpatie	nt 3	Othor	/			6 □Other (Spec	ify)
	ding Phy h. After this funeral c		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?				ry occurred	.,,,
0	Attending r death.	atic	2 Accident investigation			М	1 Yes 2] No				
Division	= 0 = -	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injury - At he building, etc. (Specif	ome, farm, st	reet, fact	ory, office	28	f. Location City or To	(Street ar own, State	nd Number or Rui 9)	ral Route Number,
V	To the Hospitel o within 24 hours at To the Funeral completely filled in	edicai C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat	h occurre	ed at the time, date a on, in my opinion, de	and place, an eath occurred	d due to the	e cause(s e, date and) and manner as d place, and due	stated. to the cause(s)
	within To th comp	Me	29b. Signature and title of certifier			:	29c. License number	r		29d. Da	te signed (Month	, Day, Year)
			1/ // Mar	wee MD			0478	22		0	1/26/	2007
•	1		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	Print)					1/00/	
	ら		Andrew Moon	ie 1900	Low	- M	aver 6	3(00)	Ba	1h'u	nove 1	81515 02
7 3	St	ate	31. Date filed (Month, Day, Year) 2007	32. Registrar's Sighe	ature Ana	A 10						
1	Regist		21418 % 2 2001	Jack town No.	1	Bedia						

07-00627 Acie I vono

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

icie Lyons		- For State	•	ertificate of L	ieaith and ivienta Death		1 No 211	7 0219
Physician	1	Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death 0309 hrs
Medical Examine		ACIE C. LYONS 4a. Facility Name (if not institution, give stree		4b	City, Town, or Location of	Month January 23	, 2007 4c. County of Deat	
	ı	Mercy Hospital	,	i i	Baltimore			
Funeral	7	5. Social Security Number 6. Sex	7. Age (In yrs.	_	If Under 1 Year If Under Months Days Hours	Min	(MM/DD/YYYY) 9. Bii Forei	gn
Director	L	213-04-0265 ¹ X M	2 F 25	Yrs.		11/13/1	1981 c	ountry) MD
any		Usual Residence of Decedent 10a State 10b. County	10c. City	y, Town or Location			·- ·	10d. Inside City Limits
* .	5	MD BALTIMORE						1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	3	10e. Street and Number		. 1	0f. Zip Code	10	g. Citizen of What Cou	ntry?
ith the 33 or notifie		1613 KIRKWOOD ROAD 11. Marital Status 12. V	Was Decedent Ever in U	IS 13 Was F	21207 Decedent of Hispanic Origin	n? (Specify Yes or No-	USA 14 Race - Amer	ican Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f shu Examiner must be notified at once and by Europea Director			Armed Forces? Yes 2 X No		specify Cuban, Mexican, I		White, etc.	
s after d		3 Widowed 4 Divorced If Yes or Da	Give Year tes:		es 2 X No specify:			LACK
215-0036 be filed within 72 hours after that Hygiene riked other than "natural"; ent, the Medical Examiner		15 Decedent's Education (Specify only hig Elementary/Secondary (0-12)	nest grade completed) ollege (1-4 or 5+)		Usual Occupation (Give ki of working life. DO NOT u		16b. Kind of Business	Industry
5-0036 ed within 72 hour tygene other than "natu		12	,	LAN	DSCAPER		LANDSC	APING
15-003 filed withi Hygiene d other th		17. Father's Name (First, Middle, Last)		[1]	18.Mother's	Name (First, Middle, M	aiden Surname)	
Z 5 6 5 5 1 6		ACTE C. LYONS 19a. Informant's Name/Relationship (Type, F	rint)	19b. Mailing A	DORG	CAS CARR per or Rural Route Numb	per, City or Town, State	e, Zip Code)
and 2 shou tealth and N tem 27 is n traumatic		DORCAS LYONS/MOTHER	1	1613 K	IRKWOOD RD.	BALTIMORE	, MD 2120	7
A 프로드 티		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re		 Place of Disposition crematory or other 	n (Name of cemetery, place)	Date	20c. Location - City or	Town, State
Baltimore, Department of He Important: If ite	1	4 Donation 5 Other Specify:		. ZION CE	METERY	1-27-07	BALTIMORE	, MD
Baltimo permit. Page Department of Important: injury or oth		21 Signature of Funeral Service Licensee	nexton					NS F.H., INC.
Physician	+	23a/Part I Enter the disease, or complication ailure. List only one cause on each line	ns that caused the deat	th. Do not enter the	1-31 LAURENS mode of dying, such as car	rdiac or respiratory arre	st, shock, or heart	21217 Approximate Interval Between Onset and
/Medical	1	Immediate Cause (Final disease a. Nec	rotizin vasc	culitis pul	monary hyperter	nsion and pulm	onary	Death
		b Fo	o (or as a consequence		disease of the	e luno		
2		if any, leading to immediate Due to	(or as a consequence	of):				
ted Insit	<u> </u>	(Disease or injury that initiated C. II	obable inject (or as a consequence	of):	1≥n substance			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate he executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the control of the con	ا <u>ت</u>	d						-
60, ate he ex hysician e burial	eaic	IF FEMALE. 23.	Ba-c,PII,27,2 If ves. outcome of pre	28a-f, perME	5, g867, 5/7/07	TT	23d. Date of deliver	
6876 pritifical ding ph	an/i	23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal		pregnancy		Day Year
Box 687 e death certific the attending p	Physician	1 Yes 2 No 9 Unknown 9	Pregnant at time of co	death 5 Othe	(Specify)			
that the dc ned by the detached f	7	Part II. Other significant conditions contr	ibuting to death but not	resulting in the unc	erlying cause given in Par	t I. 23e Did tob	pacco use contribute to	the cause of death?
S, P.C.	og po	Complications of multi	ple gunshot w	vounds with	chronic	1 Yes		bably 4 Unknown
cords law requi		osteomyelitis and mild	l acute perito	nitis		24a. Was a autops perforr	y prior to	utopsy findings available completion of cause of
tal Rec	Completed	· · · · · · · · · · · · · · · · · · ·				1 ✓ Yes 2		es 2 No
Division of Vital Records, P.O. ra after death. The law requires that the start death. The law requires that the start death. The law requires that the result of the start death. The law requires that the start death by the funeral director, page 2 should be detact.	8	25. Was case referred to medical examiner?	al: 1 Inpatient 2	✓ ER/Outpatient 3	26.Place of Death (6		Residence 6 Othe	<u> </u>
ing Physi ing Physi uneral dir	١	1 Yes 2 No 27 Manner of Death	8a. Date of Injury (Month, Day,Year)	28b. Time of Inju			ow injury occurred	
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ivision I or Attence ather death I Director: ed in by the	Certification:	Suicide 6 A Could not be			factory, office building, etc	or Town, St.	ate)	ural Route Number, City
Lospitz 1 hours 1 unera	<u>ဒီ</u>	29a Certifier		n infirmary	d at the time, date and plac		est St. BAltir e(s) and manner as sta	
Division of North Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	one) 2 Medical Examiner: On the	ne basis of examination manner stated	and/or investigation	n, in my opinion, death occ	urred at the time, date a	and place, and due to t	ne cause(s)
F 3 F 5	ž.	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo	
1200		tale brong	c- Yolla	h n	O.C.M.E.		January 23, 200	
WX		 Name and address of person who complete Patricia Aronica-Pollak MD. 	eted cause of death (Ite Assistant Medical		11 Penn Street, Bal	timore, MD 21201		
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	of a		····	
Registra	_	JAN 2-9-2007	A Comment	13. Aggain				
DITIVITETY ROV 1/200	Ť			URIGINAL				

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 863 1-29-07 yt. State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DAND Month **Physician** DANLIARY ALBERT F LEWIS 23.200 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months 83 169-16-4073 Director 05/03/1923 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No **Funeral Director** BALTIMORE MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21228 USA 23a 1026 MARKSWORTH ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 2 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò WHITE 1 ☐ Yes 2 💢 No Specify: Completed by 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) **FUNERAL** MORTICIAN and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMIS LEWIS SUF JAMES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailin Markworth ROAD BALTIMORE, MD 21228 Department of Health a Important: If Item 27 is any injury or other trau once. SARAH LEWIS / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CECILTON, MD 01/26/2007 ZION METHODIST CEM. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Math 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** GORTIL AMEURYSIN TURE 1780 principal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 autopsy performed 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 2 Accident Injury thin 24 hours after death.

the Funeral Director: A propletely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 158 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m-eAta M.O D41410 1 enuovu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P 0 RANDALSTOWN ENTER C

DHMH 17 Rev 1/2001

State Registrar

MORTH WEST 31. Date filed (Month, Day, Year)

ORIGINAL

32 egistrar's Signature

kevin Mackey 07-00345 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Medical Examiner Kevin Mackey 0950 hrs January 12, 2007 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death 3800 W. Belvedere Avenue Apt 1122 **Baltimore** NA 5 Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or Months Days Hours Min Director 46 1-21-1960 Missour: 493-70-5490 Country) 1 X M 2 Usual Residence of Decedent 10c City, Town or Location any 10a, State 10b County 10d Inside City Limits 1 X Yes 2 28a-f show NA Baltimore Md. notified at once. Director 10e Street and Number 10f. Zip Code 21201 10g. Citizen of What Country? 111 Park Avenue Funeral 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black permit Pages I and 2 should be filed within 72 hours after death wit Department of Health and Mental Hygiene Important: If item 27 is narked other than "natural", or items; injury or other traumatic event, the Medical Examiner must be I injury or other traumatic event, the Medical Examiner must be a Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married 2 X No Yes White Yes, Give Year Divorced Yes 2X No specify. Specify þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 l and Mental Hygiene Baltimore, MD 21215-0036 NA 10th grade Disabled 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Mackey Barritt Vernon Lois Be 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
111 Park Avenue, Baltimore, Md. 21201 19a. Informant's Name/Relationship (Type, Print) Guardian Annick Barber 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 1-25-07 Donation 5 Other Specify Mt. Carmel Cem. Dundalk, Md. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 0 23a Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Fatty Liver Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - tran Physician/Medical AMENDED . 27, perME, g864, X UNPENDED Box 68760, 23c If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✓ Yes To the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ After this Inpatient 2 ER/Outpatient 3 LDOA Nursing Home 5 Residence 6 ✔ Other Scene 1 🗸 Yes ဥ No 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No within 24 hours after death To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certify 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 13, 2007 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 29 Registrar

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			For State Registrer	State o	f Marylan	d / Depa <i>Cer</i>	artmen	of H	ealth a Death	and Ment		jiene	007	022	02
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	Funeral Director		010-32-8375	Sex 1∭IM 2□F	7. Age (In yrs. 64	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min. (A	ate of Birth Nonth, Day	Year)	Co	hplace (State or buntry) 1 River	- 1
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7	Physici /Medio		Joy Rae Markl	ey							January				11:55 P ^M	
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Division of Vital Records. P.O. Box 68760.

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ysician: The his certificate director, page	Be (25. Was case referred examiner?	d to medica	Hospital:			2		of Death (C	heck or	nly one)											
Physic r this	P	1 🗸 Yes 2	No		Inpatient 2	ER/Outpatient					Home 5		ce 6 🗸 0	ther: Sce	ene							
tending Pt eath. for: After the funeral	tion:		5 Pend	ding	e of Injury h, Day,Year)	28b. Time of I	njury 2		at Work? s 2 N	- 1	8d. Describe	how injury	occurred									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ertificati	. Daleido	6 Coul	d not be rmined (Specify	ce of Injury - At h	ome, farm, stree	et, factory,	office bui	ilding, etc.	2	8f. Location or Town,		Number of	r Rural R	oute Number, City							
Hospi 24 hour Funer tely fill	ပ	29a Certifier	ertifying Pl	hysician: To the be		lge, death occur	red at the	time, date	e and place	e, and d	ue to the cau	use(s) and	manner as	stated								
To the Howithin 24 h To the Furcompletely	Medical			miner: On the basis and manner	of examination a										use(s)							
	Σ	29h. Signature and til	tle of certifie	er			29c.	License					ate signed		Day, Year)							
	į,	1 Get	orbe	nu)				O.C.M	1.E.			Janu:	ary 25, 2	007								
12	1	30 Name and addres		who completed cau ssistant Medic		,	Stroot	Baltim.	ore MD	2120	1											
	ate			161		111 Penn		oailiin	ore, MD	2120	1											
St Regist					that says	Japan L	3							31. Date filed (Month, Day, Year) 32. Registrar's Signature								

			1 - For Stete Registrar	State of M	1arylan				ealth a Death		, ,	giene leg. No.	007	Ĭ	02205	
	Dhusisi		1. Decedent's Name (First, Middle, La								2. Date of Dea	Day	Ye	ar	3. Time of Death	
1 2	Physici /Medic		Elaine	S. Moor							January				11:50 p ^M	
	Examin	er	4a. Fecility Name (If not institution, giv Pickerqill	e street and numbe	r)				Location of	of Death			County of E Baltin			
			5. Social Security Number 6. S	Sex 7. A	Age (In vrs.	last birthday)		wson or 1 Year	If Under	24 Hrs.	8. Date of Birth					
В	Funeral Director			I ☐ M 2 💢 F	96	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day March 1	Year)	910	Count	ace (State or Foreign try) 'yland	
	D		Usual Residence of Decedent								nar on 1	. ,	,10			
	arylar show	-	10a. State 10b. County			y, Town or Lo	cation							10	od. Inside City Limits 1 ☐ Yes 2 No	
	28a-f	Director	Md. Baltimo	ore	IOW	son	104.7	p Code				10a Citis	zen of Wha	1 Cours		
	with Ba or		615 Chestnut	Ave.			101. 2		.204			rog. Oiliz	USA		ay i	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or items 23a or 28a-f show aumatic event, the Marical Examiner must be natified at	Funeral	11. Marital Status	12. Was Deceder		.S. 13. \	Was Dec			gin? (Spec	city Yes or No- lican, etc.)	1	14. Race - /	America		
9	after or ite	Fu	1 Never Married 2 Married	Armed Forces 1 Tyes 2 X If Yes, Give			r Yes, sp 1 □ Yes		n, Mexicar Specify:		lican, etc.)		Black, V	Vhite, e		
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12	within ene. then	dmc	Elementary/Secondary (0-12)	Coilege (1-4o +2	r 5+)	Home			,			Ow	vn Hon	1e		
Maryland 21215-0036	illed Hyg other	Be C	17. Father's Name (First, Middle, Last			1			18. Mothe	er's Name	(First, Middle,					
<u>la</u>	uld be Menta rrked ritc ev	To B	Purnell F. Sappi	ngton					Nel	llie	S1ye					
al	0 0 = =	ľ	19a. Informant's Name/Relationship (,, ,			_				Route Numbe	-				
			Mr. Ralph Moore/	Son	005				n Blv	/d. #			on, Mo			
0	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			Place of Dispo cemetery, cren	natory or	other plac		Da			cation - Cit			
Baltimore,	it. Pa intent injury injury		* 4 □Donation 5 □ Other (Special Signature of Funer I Service Lice		DI U	id Rid	-			L-30-0			esvil	ıe,	Ma.	
Ba	permit. Pages 1 en Department of Heal Important: If Item 2 any injury or other once.			100			Ruck	Tows	on Fi	inera	1 Home,	Inc	204			
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caus	ed the deat	h. Do not ent	er the mo	de of dyin	g, such as	cardiac or	on, Md.	rest,			Approximate	
	Physician		Immediate Cause (Final disease or condition	one cause on each	ine.	1 -1								,	Onset and Death	
	/Medical		resulting in death)	a. Due to (or a	s a conseq	uence of):		11	,	1				- 1	multi	
	Examiner		Sequentially list conditions,	ridia.	(d	itte	c.le	d c	Arthe	9		1	conths			
	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence of):										
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9	icate be executed physician and the burial-transit	aiE	l													
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ŏ	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								2	23d. Date of delivery				
	death	sicia	in the past 12 months? 1 🗆 Yes 2 🗷 No	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)									Month Day Year			
<u>Р</u>	that the de ted by the a detached i	Phy	9 Unknown													
s,	res tha	by	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	0	causa give	1	•	23e. Did to				e to the cause of death?	
Vital Records, P.O. Box 68760,	w require been sign	eted	Derren	1	Zon	7	-						es 2 PNo 3 Probably 4 Unknown			
Sec	sicien: The law scertificate has b irector, page 2 s	Completed									24a. Was a autop: perfor	sy	24b. Wer prior deat	e autor to con	sy findings available nptetion of cause of	
	ysicien: The is certificate hadirector, page	e Co	25. Was case referred to medical					_			1 Yes	2 2 No	10	Yes	2□ No	
	s certi	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2	ER/Outpatier	nt 3 🗆 🗅	Oth			(Check only or e 5 ☐ Resid		S □Othor /	Snacifi		
Division of	g Phys er this eral di		27. Manner of Death	28a. Date of Ir (Month, L		28b. Time of		28c. Injury Work			8d. Describe h			Specify	/	
0	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	Jay (Gai)	Injury	М		Yes 2	No						
<u>Nis</u>	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of I	njury - At h	ome, farm, str	eet, facto	ry, office		2	8f. Location (S City or Tow	treet and n, State)	d Number o	r Rurai	Route Number,	
	urs af urei D	O														
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysicien: To the beaminer: On the basis and manner	of examina	owledge, deatl ation and/or in	n occurre vestigatio	d at the tine n, in my o	ne, date an pinion, dea	nd place, ai ith occurre	nd due to the o d at the time, o	ause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)	
	o the	Me	29b. Signature and title of certifier	and mainer	1		2:	9c. License	number		2	29d. Date	e signed (A	fonth, L	Day, Year)	
	- 5 - 0		I MANTE	- hil	10	us	6	125	20.	J		Jan	14.	26	2007	
	h		30. Name and address of person who Walk Ricky C	completed cause of	f death (Iter	п 23а) (Туре.	Print)	^	C:	0	0.	, , ,	7			
	3			SBAC	6700	N-	Ch	nle	, 17.	Hoel	to.M.	d 2	120	٤		
	Sta Regist		31. Date filed (Month, Day, Year)	32 Regis	strar's Signa	ature	and I									

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Marylar		ment of H			jiene	2007	02206
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Vane	3. Time of Death
	Physici /Medio		EMANUEL	MILFORD,	SR			Janua		5. 20%	1235M
	Examir		4a. Facility Name (If not institution, give	street and number)	1 1/ 1	b. City, Town, or	Location of Dea	th 10	4c. (County of Death	1:00
			tranklin sq	mare Ho:	Spiral	4	osea	ale		1301	TIMOVE
	Funeral		5. Social Security Number 6. Set	MM 2□F		f Under 1 Year lonths Days	If Under 24 Hrs Hours Min	. (Month, Day	, Year)	Cou	place (State or Foreign ntry)
	Director		247-34-1192 Usual Residence of Decedent	80				12 09	9 19	26	SC
	within 72 hours efter death with the Maryland ene. Than "naturel", or lieme 23a or 28a-f show na Madical Examinat must be notified at		10a. State 10b. County	10c. Ci	ty, Town or Locati	ion					10d. Inside City Limits
	Mar B-f st	访	MD BALTIN	MORE	TURNE	R STATIO	ON				1 Yes 2 □ No
	or 28a-f	Director	10e. Street and Number			10f. Zip Code		1	0g. Citiz	en of What Cou	ntry?
	23a Mil	je j	131 CHESTNUT STRI	EET		212	22			USA	
	ep .	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was	Decedent of Hi	spanic Origin? (Specify Yes or No- rto Rican, etc.)	1	 Race - Ameri Black, White 	
36	or in	by Fi	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2Ă∏ No If Yes, Give		Yes 2 No				Specify: BLA	
8	72 hours efter dea "naturel", or Iteme often Exeminer m	g pa	15. Decedent's Edu	Year or Dates:	16a Docadoni	t's Usual Occupa	ation			d of Business/Ir	
21215-0036	in 72	Completed	(Specify only highest grad	le completed)	(Give kind		turing most of wo	orking	TOD. KIII	O OI DUSINGSS/II	laustry
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Ď	be ilied within 72 hours efter death with the Maryla tal Hygiens that "Yeller than "naturel", or lieme 23s or 28s-f shoy event, the Madical Examinat must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden S	Sumame)	
<u>a</u>	ould be Mental arked o	ToE	LESTER MILFORD				MARY BE	ROWN			
ar	# PE		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing A	ddress (Street a	and Number or A	ural Route Number	, City or	Town, State, Zi	Code)
Σ.	and and and and and and and and and and		GLENNIE M. MILFOR	· · · · · · · · · · · · · · · · · · ·			T ST., F	BALTO., M	D 21	222	
ore	of He		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F		Place of Disposition cemetery, cremate	on (Name of ory or other plac	θ)	Date	20c. Loc	ation - City or T	own, State
Ë	Pages ment of I tent: If its jury or o	١,	4 ☐ Donation 5 ☐ Other (Specify)		. STANIS					IMORE,	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 is eny injury or other tra		21. Sonatule of Funeral Service Licens	90 701 4	22. Na	ame and Addres	s of Facility JA	MES A. M	ORTO	N & SON	S F.H., INC
	40 2 e 0	0.00	23a. Palv. Enter the disease, or compl shock, or heart failure. List only or	1. John				ET, BALTO		D 21217	Approximate
	Physician / Medical Examiner The private ransit pr	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	quence of).		.arce)	γ			
). Box 68760,	eath certific ettending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of c			23	3d. Date of deliv	ery Day Year		
P.0	thet fhe d ed by the detached	ج و		atabutian ta daath but not co		4 :	- (- B-4)	ana Didaa			he cause of death?
ords,	n requires the been signed should be de	ted by	Part II. Other significant conditions con	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco							
Records,	he lav e has	Completed			.,.			24a. Was a autops perform	ned?	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
<u>ita</u>	ilcien: T certificet rector, pe	8	25. Was case referred to medical				26. Place of De	ath Check only on	e)	10 165	2010
of Vital	Z 25	To B	examiner?	lospital: 1 Appatient 2	ER/Outpatient	3 DOA Othe	·c	Home 5 ☐ Reside		Other (Specia	5y)
	ng Ph ter th nerat		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho			
Division	f or Attending effer death. Director: After in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	ome, farm, street,	M 1 🗆 1	/es 2□No	28f. Location (St City or Town	reet and n, State)	Number or Run	al Route Number,
۵	To the Hospital of within 24 hours et of the Funeral Discompletely filled in		(Uneck only 2 Medical Exami	sician: To the best of my kno	owledge, death oc	curred at the tim	e, date and place	e, and due to the ca	ause(s) a	ind manner as s	tated.
	the I hin 2. the I	Medical	One)	and manner stated.							
	To To		29b. Signature and title of certifier	100	MA	29c. License	number	11.	ed. Date	signed (Month,	uay, Year)
	}		Inn	regul	111/	100	0650	44	112	5/01	
1	D		30. Name and address of person who co	WYELKI 90	n 23a) (Type, Prin	Whin .	Squan	Dr.B	alt,	More	M 21239
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	11	U				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14 Day 2007 Year Nash 2:20a Lane Ernest /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) 4–2–1922 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Md. **Funeral** Days 1 X M 2 □ F Months Hours Min. 84 218-14-5929 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show t be notified at Baltimore 14 Yes 2 □ No NA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2509 N. Ellamont Street USA 21216 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must t Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: Black 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't. Building Security 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lane Nash Ernestine Howard Charles မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. Edith Nash Carter Cousin 1201 N. Ellwood Avenue, Baltimore, Md. 21213
Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem. Pk. 4 Donation 5 ☐ Other (Specify) 1-29-07 Arbutus , Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East lady Wan 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Anterios cleud 1cons disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe es 2 this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 ER/Outpatient 3 DOA မ 1 Inpatient After th funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

or Attending

Baltimore, Maryland 21215-0036

filed within 7 Hygiene,

Pages 1 and 2 should be nent of Health and Mental

within 24

hours after

State Registrar

29b. Signature and title of certifier

29c. License number 125643

(Item 23a) (Type, Print)

6565 N. Chaves St Sute 201/Balto endal R taulkner MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 26, 2007 **Physician** 2:07 P CLARA **PINCUS** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 □ F Director 219-18-8261 81 06/26/1925 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d, Inside City Limits or 28a-f ahow other traumatic avant, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director MD MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 933 GENTLEWOOD STREET 20878 or Itams 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should ba filed within 72 hours after on and Mantal Hygiene. I a markad othar than "natural", or Itar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Ā 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SILVERMAN MAX TOBIE **EBENSTEIN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 ia n any injury or othar traun 933 GENTLEWOOD STREET - GAITHERSBURG, MD 20878 BONNIE RUBINSTEIN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 01/28/2007 BALTIMORE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MYDCARDIAL INFARCTION /Medical **Examiner** RONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ ¥6 Month 4 □ Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CAR DIDMYOPATHY 1 Tyes a No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No DEMENTIA 24a. Was an certificate has Vital 1 Yes No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Certification: After t Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours To the Funaral Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number www. DO18084 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH PATEL 32 Registrar's Signature MONTROLE RD 6121 State Registrar

			for State	State of Ma		artment of Health		giene	
		-	Registrar 1. Decedent's Name (First, Middle, La	(c)	Cei	rtificate of Deat	2. Date of De	Reg. No.	3 Fire of Dooth
	Physic		11:11:am H	e nr V	Powell	/	Month A	25 2007	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, given	e street and number)	1000211	4b. City, Town, or Location	n of Death	4c. County of Death	
	in.	à	3802 Colborn	e Rd		Baltimo		NIA	
×.	Funeral Director		5. Social Security Number 6. \$	Sex 1 M 2 □ F 7. Ago	e (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of Bird Min. (Month, Da	th y, Year) 9. Birth Cou	place (State or Foreign
			Usual Residence of Decedent		10.00.7			12/11011	~ Cirojing
	the Marylar 28a-f show	ū	10a. State 10b. County		Baltin				10d. Inside City Limits 1 ☐ res 2 ☐ No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number		139171m	10f. Zip Code		10g. Citizen of What Cou	
	th with 23a or	al Di	3802 Colbor	ne Kl				U.S.A.	,
	ter dea	uner	11. Marital Status	12. Was Decedent if Armed Forces?		Was Decedent of Hispanic C f Yes, specify Cuban, Mexic	Origin? (Specify Yes or No an, Puerto Rican, etc.)	- 14. Race - Ameri Black, White	ican Indian,
36	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 No Specif	fy:	Specify 8/C	ck
5-0036	72 hours "natural",	ted	15. Decedent's E (Specify only highest gr	ducation		dent's Usual Occupation kind of work done during me	net of working	16b. Kind of Business/Ir	ndustry
21	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life. I	DO NOT use retired)	ost of working	cl L	in atal
d 21	filed v Hygie ther t		17. Father's Name (First, Middle, Last)		abore V	her's Name (First, Middle,	Maiden Sumame)	meraj
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	To Be	Fox Powell			(ν)	Vie Low	ho fton	
lary	alth and N	6 0	19a. Informant Name/Relationship	Type, Print)	19b. Mailir	g Address (Street and Num	ber or Rural Route Numbe	er, City or Town, State, Zi	p Code)
	s 1 and of Health Item 27 other to	1	Alberta Powell 20a. Method of Disposition	wite	20b. Place of Dispo	2 Olhorhu	e Rd bo	20c. Location - City of T	Own, State
altimore	Pages nent of nt: if it iry or o		1 Maurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specie		cemetery, cren	natory or other place)	Ž. (2 202	K is ctor	own, State
alti:	- t 2 -		21. Signature of Funeral Service Lice		Vause	Name and Address of A	La la de Fu	neral Setu	CA P.A.
ä	permi Depa Impo		· Carlton C.	Dougla	1	701 Me cull	ok 81. B	altimore, h	1. 21217
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not ent	er the mode of dying, such a	as cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
ji.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Me	fastatic	Colon	Cancer		~ 275.
	Examiner		1		a consequence of):				
W.	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):				
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as:	a consequence of):				
8760,	cate be executed obysician and the burial-transit	dicai E	· ·	d	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
9	rtificat ng phy as th	Medi	IF FEMALE:						
Вох	ath ce ittendii or use	lan/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deliv-	ery Day Year
P.O.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death 5	Other (specify)			ou, rou
	res that igned b be deta	by Pt	Part II. Other significant conditions	ontributing to death bu	ut not resulting in the ur	nderlying cause given in Part	11. 23e. Did to	obacco use contribute to t	he cause of death?
Records,	v require been sig should b						1 🗆 Y	'es 2□No 3□Prob	pably 4 Minknown
Sec.	has be	Completed			24a. Was autop	an 24b. Were auto sy prior to co	opsy findings available impletion of cause of		
<u>a</u>		e Col	OF Was and referred to made t					2D No 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	Others	ce of Death (Check only or Nursing Home 5 PResid		64)
Division of	<u>F</u> = <u>B</u>		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28c. Injury al Work?		ow injury occurred	<i>y)</i>
sio	tendi death. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b	n		M 1 Yes 2			
Div	after Direct in by	Certification:	4 Homicide determined	building, etc	iry - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (S City or Tow	treet and Number or Rura n, State)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Ph	ysicien: To the best of	of my knowledge, death	occurred at the time, date a	and place, and due to the c	ause(s) and manner as s	tated.
	the H hin 24 the Fi	Medical	one)	and manner sta	ted.	estigation, in my opinion, de	eath occurred at the time, o	date and place, and due to	o the cause(s)
	-/	-	29b. Signature and title of certifier	~ A	Hundi	7 29C. License number	42	James and Same	Day, Year) 26, 2607
1	9		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type I	Print)	1	7	,
U	ζ			no 1009	, Frederi	de Rd. Cat	asulle.	4) 2/2 28	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re gistra	ur's Signature	estigation, in my opinion, deleast at the time, date a restigation, in my opinion, de 29c. License number 1 369 Cerint)			
1	900	-2	W. 111 Pd S	A STEER					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Johanna Clara Remeikis 01/23/2007 1:18 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 182 Dale Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Yrs 216-20-9143 Director 86 03/04/1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f shormust be notified at Funeral Director 1 ☐ Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 182 Dale Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 Divorced Specify: White natural Completed th and Mental Hygiene. 7 Is marked other than "natur traumatic event, the Medical" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Bartz ပ Augusta Drager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 r other tra 8341 Rita Mitchell / Daughter Sail Court, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specity) Holy Redeemer Cem 01/26/07 Baltimore, 21. Signature of Juneral Septice Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ABDUMAL CINDID disease or condition resulting in death) moule /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FÉMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ATHERUSCEMIC CARDIOVASLYVANDOS 2 No 1 Tes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No ate has page 2 s autopsy performed? Yes 2 No certificate CCINEUTS 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home ို 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending r death. investigation 1 Yes 2 No 2 ☐ Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M, traci

JAN 29

30. Name and address of person who completed cause of dath (Item 23a) (Type, Print)

2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

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29c. License number

29d. Date signed (Month, Day, Year)

Red 57 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vear DOLORES PATRICIA RUE JANUARY 2007 /Medical 26, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 213-36-8233 Director 67 2/22/1939 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at a or 28a-f shot be notified a MD BALTIMORE TOWSON 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21286 or items 23a USA 8311 PLEASANT PLAINS ROAD r than "natural", or items 23a the Medical Examiner must by Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r RETAIL CREDIT AND Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE CASUALTY SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be in Department of Health and Mental Important: If Item 27 Is marked o EWELL CLAY HENDERSON GEORGIA NASH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES C. RUE/HUSBAND 8311 PLEASANT PLAINS ROAD TOWSON, MD 21286 Baltimore, 20b. Place of Disposition (Name of Cemetery, crematory or other place)
DULANEY VALLEY MEM. 20a. Method of Disposition 20c. Location - City or Town, State ö 1 Burial 2 Cremation 3 Removal from State 1/30/2007 COCKEYSVILLE, MD inlury 4 ☐ Donation 5 ☐ Other (Specify) **GARDENS** 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenslee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Severe **Physician** disease or condition resulting in death) montas /Medical Due to (or as a consequence of): crohns disense Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical the aftending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 1 No 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospical Hospital: 1 ☐ Yes 2 ☐ No ပ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Injury at Work? 1º Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

Division or Vital e Hospital or Attending P 24 hours after death. e Funeral Director: After t within 24 hours at To the Funeral Completely filled i

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of portifie

, and

and manner stated.

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 26,200>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St. bolto. Md 2:20% 6701

31. Date filed (Month, Day, Year JAN 2

32 Registrar's Signature

			1 - For State Registrar	State of M	aryland / Depa	artment of H		, ,	2007	02213	
5,			Registrar 1. Decedent's Name (First, Middle, Last)	Cel	illicate of t	Dealli	Reg.	Noc U U I	3. Time of Death	
	Physici		Cynthia		icklin				3 200 ^{Year}	5:22p M	
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		4c. County of Dea		
	LAdiiii	iei	1761 Montpelier				Baltimore		NA		
	Funeral		5. Social Security Number 6. Se		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 7–9–194	ear) 9. Bir	thplace (State or Foreign	
د معتبر	Director	5	214-50-5153 1L Usual Residence of Decedent		60 Yrs.			7-9-194	6	Md.	
	and		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	Mary -f sh	ţ	Md. NA		Baltin	nore				1X Yes 2 □ No	
	r 28a	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?	
	h wit	교	1761 Montpelier	Street		212	18		USA		
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whi		
36	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 21 If Yes, Give Year or Dates:	No	1 □ Yes 2 X No	Specify:	7110411, 010.7		Black	
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pu	be filed within 72 ho ttal Hygiene. do other than "natun event, the Medical	Be (17. Father's Name (First, Middle, Last)					e (First, Middle, Maid	den Surname)		
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e,	s 1 and 2 f Health Item 27 i	i	20a. Method of Disposition	OLUTIAGA	20b. Place of Dispo				Location - City or		
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Ba	permi Depa Impo any Ir		> Blade	2 (1)				, Baltimo		21202	
Æ.	7 7		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that cause	d the death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between	
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687	ficate phys s the	edical		j							
Box (certii nding Jse a	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of de	liven	
	death certifi e attending d for use as	icia	in the past 12 months?	4□Pregnant a		Ectopic pregnancy Other (specify)			Month	Day Year	
P.0	that the death certificed by the attending podetached for use as	Physician/Me	9 Unknown	9□Unknown							
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ecc	ne law r has be ge 2 sh	ple	6 GEBR					24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of	
<u> </u>		Completed	(3) Osteo	Simontes				performed 1 Yes 2 ☑	? death?	2 □ No	
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	leanitely.		Tau.		h (Check only one)			
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n	funel	ioi	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	Work	y at k? Yes 2 □ No	28d. Describe how in	njury occurred		
Si	Attending r death. ector; After by the fune	icat	3 Suicide 6 Could not be	28e. Place of ini	ury - At home, farm, stre			28f. Location (Street	and Number or R	uni Pouto Number	
Division or Vital Records,	after after Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	out, ractory, cines		City or Town, St	ate)	arai noute Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, death	occurred at the tin	ne, date and place,	and due to the cause	e(s) and manner as	s stated.	
	he Hc n 24 he Fu pletel	Medical	(Check only 2 Medical Examl	ner: On the basis of and manner st	of examination and/or in- ated.	vestigation, in my o	pinion, death occur	red at the time, date	and place, and due	e to the cause(s)	
	To the Community	Σ	29b. Signature and title of certifier		\ N	29c. License		29d.	Date signed (Mont	h, Day, Year)	
	3		1 Contail	<u></u>	M.D.	04	10490		1/24/	2017	
	V		30. Name and address of person who co		leath (Item 23a) (Type,	forle red	An 07.	-1211 N	10 2 (21)	
	(ar's Signature	(out Ica	.3000	()	LI3 616	_	
gr.	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 9 2007	Z. negisti	A Solyllature	Nº 2					

07-00589		Please Type or P							ible.			
Stephanie Scott		State of N - For State Registrar	aryland / De/ C	•	ent of Hea ate of Dea		tal Hyg	-	g. N o.	200	7 0	2211
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Stephanie		S	cott			. Date of Death	Day , 2007	Year	3. Time of E 1919 h	
		4a. Facility Name (if not institution, give stree Johns Hopkins Hospital	t and number)			, Town, or Location imore	of Death		4c. C	ounty of Death NA	1	
Funeral Director		5. Social Security Number 6. Sex 212–88–6002 1 M	7. Age (In yr	s. last birt	hday) If Ur Mor Yrs.			8. Date of Birth		Foreig	thplace (State in untry) M o	
/land -f show any once.	tor	Md. 10b. County	10c. C		or Location ltimore		_				10d Inside	,
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 604 Chestnut Hill	Ave.		10f. 2	ip Code 21218		10		n of What Coul USA	ntry?	
er death w	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Opales:			13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:				o- 14. Race - American Indian, Black, White, etc. Specify. Black			lack,
72 hours "natur		15. Decedent's Education (Specify only hig Elementary/Secondary (0-12)	nest grade completed ollege (1-4 or 5+)) 16a I		al Occupation (Give orking life, DO NOT			16b. Kind	d of Business/I	ndustry	
5-0036 iled within 77 Hygiene d other than the Medical	Completed	12th grade 17. Father's Name (First, Middle, Last)		Sa	alad Bar	-Manager	's Name (F	irst, Middle, M		er Fres	sh Mar	ket
21215. 21215. Suld be filed Mental Hy marked of	Be	Roger	William		Scott	Shi	rley			Clant		
MD 2 d 2 shoul th and M n 27 is m numatic	٩	19a. Informant's Name/Relationship (Type, F Shirley Goldsborous				ss (Street and Numestnut Rd.						54
Ges I and tof Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	moval from State	cremate	ory or other place			Date		cation - City or		
Baltimore, permit Pages I at Department of He Important: If ite Imjury or other it		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	aner	Mt. 2		d Address of Facility E. North	1-27 Ma Ave.	arch F.	н. Е	nsdowne ast , Md.	21202	
Physician /Medical xaminer	Physician/Medical Examiner	Due to Du	ple Injuries (or as a consequenc (or as a consequenc (or as a consequenc	e of):	deriter the mod	ordynig, such as c	ardiac of re	sspiratory arres				
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and a should be detached for use as the burial - transit		3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 9	Live birth Pregnant at time of Unknown	2 fdeath 5		ecify)	pregnanc		Mo		ay	Year
ds, P.O. equires that the een signed by ould be detact	à	Part II. Other significant conditions contr	buting to death but no	ot resulting	in the underlyii	ng cause given in Pa	ırt I.		2 🗸 N	contribute to 3 Prob	ably 4 🔲 (Jnknown
Division of Vital Records, rat or Attending Physician: The law requirers after death and Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed	25. Was case referred to medical				26.Place of Death	(Chook and	autopsy perform	/ ned?		ompletion of	
Vital Inhysician:	To Be	examiner? 1 ✓ Yes 2 No	ı inpatient 2	✓ ER/Ou	utpatient 3	IOthas -	Nursing I		esidence	e 6 Other		
Sion of V vtending Phydeath ctor: After thy the funeral		1 Natural 5 Pending	a. Date of Injury (Month Day Year) an 21, 2007	28b. 1 1835	Time of Injury hrs	28c. Injury at Work 1 Yes 2 ✓	ر حا	Bd. Describe ho edestrian st				
E 6 E	Certification:	2 M Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street (Spec							Street and Number or Rural Route Number, City tate) Ave & Greenmount Ave, Baltimore, MD			
To the Hos within 24 h To the Fur completely	Medical	29a Certifier 1 Certifying Physician: To Check only 2 Medical Examiner: On the	e basis of examinatio									
F 3F 5	M	29b. Signature and title of certifier 29c. License number O.C.M.E.								e signed (Mor ry 22, 2007		,
3		30. Name and address of person who comple Ling Li, MD Assistant Medica			Street, Bal	timore, MD 212	01	•			 .	
Sta Registr		1. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	Acces o							
DHMH 17 Rev 1/20		VMI4 (, V - (1111/	140653	OR	IGINAL	-						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Isaiah ANUARY Spriggs 2007 Ø2:29P M /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 6. Sex 1 ☐ ★M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth
Month, Day, Year,
1-25-1962 Birthplace (State or Foreign Country)

Mo **Funeral** 44 216-78-7046 Yrs Md. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Md. 1 Yes 2 No NA Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be 5050 Mayview Avenue 23a 21206 r death v Funeral USA items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ▼ Married 9 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: β Specify: Black 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Disabled 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o Isaiah Paul Spriggs ပ Ann Shirlev Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; if item 27 is any injury or other trauonce. Ann Spriggs Mother 2113 Gliftwood Avenue, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cem. 4 □ Donation 5 □ Other (Specify) 1-27-07 Baltimore, Md. 21. Signature of Funeral Service Licensee March F.H. East 22. Name and Address of Facility 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METHICILLIN RESISTANT STAPHYLOCOCCAL AUREUS /Medical Due to (or as a consequence of) Examiner BACTEREMIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed burial-transi Box 68760, 🛷 HUMAN IMMUNODEFICIENCY VIRUS Due to (or as a consequence of): physician INTRAVENOUS DRUG ABUSE Physician/Medical the attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 ☐ Other (specify) Ö 9□Unknown 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş ALCOHOLIC CIRRHOSIS 1 ☐ Yes 2 ****No 3 ☐ Probably 4 ☐ Unknown Completed page 2 s 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has autopsy this certificate I or Vital 2 No 1∏ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient
Date of Injury ၉ 2 ER/Outpatient 3 DOA Manner of Death After t 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident (Month, Day Year, 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by or A 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and litle of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW. M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar JAN 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Santos 9:25 pm 2007)oca Jan 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2**X**F 57 238-86-7754 04/13/1949 Director NC Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Anne Arundel Hanover 1XIYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21076 USA 7612 Harmans Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Black 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 Wildowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Administrative Technician Medical Records permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If item 27 is marked other any injury or other traumatic event, <u>It</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Dickens Marie Haywood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 - B Esteli Drive, Beauford, SC 27886 Geren R. Santos / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Haywood Family Date UNIKA. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State Tarboro, NC 4 □ Donation 5 □ Other (Specify) Cemetery Tangend Address of Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transi Due to (or as a consequence of): attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No al or Attending Physician: safter death.
Il Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DCA P 28a. Date of Injury 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760 P.0. Division or Vital Records, completely filled in by To the Hospital within 24 hours at To the Funeral D

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seema Nayar 22 S Greene St Bulhmore MD 31. Date filed (Month, Day,

NEMUM M.D.

State Registrar

Ima

(Check only one)

29b. Signature and title of certifier

29c. License number

P21212

29d. Date signed (Month, Day, Year)

Jun 25

			1 - For State Registrar	State of Marylan	•	tificate of		ieniai Hy	giene Reg. No.	2007	0221
	Physici	an	Decedent's Name (First, Middle, Las RODERICK SHE	PARD, SR				2. Date of De Month	eath Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	717102.11		County of Death	
AT.	4 4 4 4 4 4 4		and the state of	th make		Bhamw	-				
	Funeral Director		5. Social Security Number 6. Security Number 17 246-20-6676 17 Usual Residence of Decedent	7. Age (In yrs. I I M 2 □ F 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da JAN . 1	th ay, Year) 2, 19	Cou	place (State or Foreign intry) TH CAROLINA
	yland now at		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	MARYLAND	BAI	LTIMOR	Ε					1 XYes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Code			9	zen of What Cou	intry?
	ns 23 must	Funeral	4566 DERBY MANOR 11. Marital Status	DRIVE 12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	21215 Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No	U.S.	• A • 14. Race - Amer	ican Indian,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>	þ	1 □ Never Married 2 □ Married 3 🖔 Widowed 4 □ Divorced	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: (UNK		f Yes, specify Cuba 1 □ Yes 2 🔯 No	an, Mexican, Puerto Specify:	Rićan, etc.)		Specify: BLA	
5-0	72 ho 'natur dical I	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	lent's Usual Occup	durina most of worki	ing	16b. Kir	nd of Business/li	ndustry
and 2121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired ESMAN	a) -		RAT	ILROAD	
d 2	Hiled Hygi Other ent, t	Be Co	17. Father's Name (First, Middle, Last)	1	Litti	3014111	18. Mother's Name	(First, Middle			
/lan	weld be Menta arked attc ev	To B	HAZEY SHEPARD				MINERVA	NIXON			
Jan	2 sho	ľ	19a. Informant's Name/Relationship (7)		19b. Mailin	g Address (Street	and Number or Rura	al Route Numb	er, City o	r Town, State, Zi	ip Code)
9	1 and Health em 27		ROMONA PERRY (DAU 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	ZE., BALTI	MORE,		L239 cation - City or T	own. State
JO.	Pages ent of nt: If it ny or o		1 Burial 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Specify	Pamoual from State	emetery, cren	natorý or other plac COMMUNIT		0.7		PSTEAD,	•
altimore, M	permit. F Departmi Importar any Infur		21. Signature of uneral Service Ut en		121217	. Name and Addre	ss of Facility		HATI	SILAD,	NO
m	permir Depar Impor any Ir	())	Lennis Fi	Unem		P.O. BOX		GAW, N		425	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	dications that caused the death one cause on each line.		er the mode of dyir	ng, such as cardiac c	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	-					
99.		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	ience of):						
68760,	icate be executed physician and s the burial-transit	cal Exar	that initiated events resulting in death) Last	Due to (or as a consequent	ience of):						
	± 50 €	Medical	15.551111.5	VI.							
.O. Box	requires that the death certif een signed by the attending rould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other <i>(specify)</i>	у		2	23d. Date of deliv Month	/ery Day Year
0	s that ned by		Part II. Other significant conditions co	ontributing to death but not resu	ılting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ord	w require been sig should b	ed by	DAGETES MELLITE	<i>J_</i> \$				10	Yes 2	□No 3 Pro	bably 4 🗀 Unknown
ecc	aw as b	Completed	DEMENIA					24a. Was		24b. Were aut	opsy findings available ompletion of cause of
a B	yslcian: The law is certificate has t director, page 2 s	Con	COPD / ASAMA					perfe 1□ Yes	ormed?/	death?	2 No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		t 3 DOA Oth	26. Place of Death		,		
9	Phy ald ald	: To	27. Manner of Death	28a. Date of Injury	28b. Time of	· OLI DOA	4 Li Nursing Hoi	me 5 ☐ Resi 28d. Describe			ify)
ion	Attending I ar death. ector: After by the funer	atio	1 Accident 5 Pending investigation	(Month, Day Year)	Injury		k? Yes 2 □ No				
Division or Vital Records,	a # 등 등	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	1	28f. Location (City or To	Street and wn, State)	d Number or Rui)	al Route Number,
	he Hospital n 24 hours a he Funeral I pletely filled	Medical	29a. Certifier 1 ☐ CertifyIng Phyone 2 ☐ Medical Example 2 ☐ Medi	vsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death tion and/or in	occurred at the tire vestigation, in my control	me, date and place, opinion, death occurr	and due to the red at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier			29c. Licens	e number			e signed (Month	
				MOU		PES	-000		Jim.	Mrny 25,	227
	H		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, I	Print) OF BAZI	mure				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture A	andi)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 Day Month **Physician** 11:30 Dennis Elmer Scanlon 2007 JAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 09-15-1941 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** 65 219-38-8612 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 2718 E. Fairmount Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Local 101 Union Carpenter 5<u>th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Schenider John Scanlon Elmer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2718 E. Fairmount Ave., Baltimore, MD 21224 Joann Scanlon / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State W. Arundel Crematory 01/26/2007 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, P.A. 21. Signature of Funeral Service Licenses 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Coronay years resulting in death) /Medical Due to (or as a consequence of): Examiner Stypenhunor Sequentially list conditions, if any county cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ma betwo burial-trar Due to (or as a consequence of): Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) led by the a 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ Mo 24a. Was an autopsy performed certificate 2 **M**0 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 57088 Than bon MD, FACP

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Bastimus.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

		1	State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No: 0 0 7 0 2 2 1 9
	Physicia	an	Registrar Decedent's Name (First, Middle, Last) Charles J. Sauly, Tr. 2. Date of Death January 24 Zoo7 7:00 PM
	/Medic Examin Funeral Director	er	a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3c. County of Death 4d. County of Death 4d. County of
	death with the Maryland ime 23a or 28a-f show r must be notified at		State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1
36	J within 72 hours after death with the Marylan riene. I then "natural", or Iteme 23a or 28a-f show It a Marical Examinat must be notified at	rai Di	9401 Wordsworth Way, Unit 101 1. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 21117 21117 21117 U.S.A. 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Amed Forces? 16. Yes, Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: White
d 21215-0036	하는 하는 하는	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist 16b. Kind of Business/Industry Can Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	d 2 should be f th and Mental H 7 Is marked of traumatic sve	To Be	Charles Sauer Louise Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117
Baltimore, M	permit, Pages 1 and 2 Department of Health Important: If Item 27 I sny injury or other tre 20059.		Ann C. Brown Daughter 9401 Wordsworth Way, Unit 101 Owings Mills, Maryland 20a. Method of Disposition 1 © Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Holy Cross Cemetery 1-27-2007 Brooklyn, Maryland 21. Signature of Fund in Service Licensee 22. Name and Address of Facility 1050 York Road Towson, Maryland 21204
\$,092	Physician /Medical Examiner page 14 pa	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Or on any of the final disease. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of the Interval Between One of th
.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year
٥	w requires that I been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whknown
Vital Records,	ysicien: The law re iis certificate has be director, page 2 sho	e Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
of Vi	g Physicie er this cert ieral direct	To B	examiner? 1 Yes 2 No
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	1 SNatural 5 Pending investigation 2 Accident investigation 3 Suicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 4 Snatural 5 Pending investigation M 1 Yes 2 No 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number. City or Town, State)
	Hospital 24 hours a Funeral etely filled	dical C	29a. Certifier (Check only one) 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the compl	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 135391 January 25, 2007
	541		30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Ming VI MD 3320 Genson Avenue, Baltimore. Maryland 21227
**	St Regist	ate trar	31. Date filed (Month, Day, Year) JAN 2 9 2007 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Anna Lee Shade 6:00 PM M 14,2007 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton, Prince George's 9. Birthplace (State or Foreign Country) Washington DC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 1,1939 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Months Days Hours 67 579-52-6572 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 Spell Road 20735 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2√€ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify: Specify: Black þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Department of nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Twelve College (1-4or 5+) Two Program Coordinator <u> Health & Human Services</u> or other traumatic event, alth and Mental Hv. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit, Pages 1 and 2 should be Department of Health and Mental Important; If Item 27 Is marked c any Injury or other traumatic man Unknown Ethel Halloway 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5906 Spell Road, Clinton, Maryland 20735 Monica Sellman/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 24, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Doration 5 Dother (Specify) Harmony Memorial 2007 Clinton, Maryland 21. Sign wire of Funeral Service 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** filled /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title my) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SE Such 310 Washing has DC 20032 1328 Southern avenue Kichard laborer mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day :50AM Month Year **Physician** January Genevieve Pauline Schultz 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dear 4b. City, Town, or Igocation of Death Examiner seo Squate Frankin S 5. Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) NOV24,1921 age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 20 F Months 85 214-16-6537 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Md. Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2605 Ambler Road 21222 U.S.A. items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 1 ☐ Yes 2 No II Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Production Line Worker Esskay Meats 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of should be Stephen Piotrowski Stella Kowalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any injury or other trai 90008. Gerald Schultz-son 1734 Lynch Road Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Ceml-26-07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Raczorowski Funeral Home, PA 21. Signature of Funeral Service License 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death taemobt Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed PSIS Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔊 No Day ğ Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by ete has been signe page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔀 No 17 Icratient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) andit.
Tor: After th.
Tuneral die 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural Accident Injury 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death.
To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a, 25, 26, 27, 29e part of G863; 01/26/07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Thompson Month THOMPSON **Physician** 205PM /Medical 4a. Facility Name (If not institution, give street and nymber)
HOWARD COUNTY (FNERM) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY HOWAKE COLUMBIA MO 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days 219-62-61084 Usual Residence of Decedent .03 Director Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Columbia Howard County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Goldamber 1. B. A 14. Race - American Indian, 21045 Funeral Garth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harmon BobbiH Georgia 2 Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City Franklin D. Thompson / Husbany 21045 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) Harrison Forest Cometry :01.24.07 Owings mills, mD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C. Greene Juneral Service 23a. Part Eller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Rd Randallstain, MO21/33 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ischemia -sigmuid vulava **Physician** /Medical nent syndrome - septic shock Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): U Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? shock, vespiratory Be Completed by 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2X No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 930

Registrar

State

31. Date filed (Month

DHMH 17 Rev 1/2001

3350 WILKENS AVE SUITE 307

30. Name and address of person who completed use of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 12:32 AM BROW THORNTON JANUARY 25 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW HEDICAL CENTER BAUTIMORE 5. Social Security Number If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In yrs. last birthday) Months 1√2 M 2□ F Days Hours Min 33 01 - 19 - 1974213-19-5055 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits M∑Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry 18. Mother's Name (First, Middle, Maiden Surname) LOUVENIA PRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) o. Mailing Address (Street and Number of Figure 1988), MD 421 NEW PITTSBURG AVENUE, TURNER STATION, MD 212 20c. Location - City or Town, State BALTIMORE, MD JAMES A. MORTON & SONS F.H., INC _1701 LAURENS ST., BALTO., MD 21217 23a. Pa (* Enter the disease, or complications is at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death 4 Hours MAGI 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) JANUARY 25,3007 BALTIHORE, MO 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato or wie	•	Certificate of		, ,	eg. No.2 0 0	7 02225
15	Physici	an	1. Decedent's Name (First, Middle, La	•	-			2. Date of Dear	th Day Yea	3. Time of Death
À	/Media			Thouin				Jan.25,	2007	1:20am M
	Examir	er	4a. Facility Name (If not institution, given Anne Arundel Me		.036		or Location of Death	1	4c. County of De	
- 1,000					e (In yrs. last birti	Annapo If Under 1 Year		8. Date of Birth	Anne Ar	
ľ	Funeral Director			1 M 2 □ F		rs. Months Days	Hours Min.	Oct.18,	1935 Gr	Birthplace (State or Foreign Country) and Rapids,MI
	yland yow at		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Mar la-f st tified	ctor	MD Anne Ai	rundel	Cı	rofton				1 XYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	s 23a	era	2626 Salford Di		Service III 0	21114	New and a Out-land (O		USA	merican Indian,
21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show disal Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent If Armed Forces? 1 MYes 2 □ N If Yes, Give Year or Dates:		13. Was Decedent of In If Yes, specify Cub		o Rican, etc.)	Black, W	hite, etc.
5-0	in 72 hours i "natural"; lectral Exa	Completed	15. Decedent's E (Specify only highest gr	ducation rade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of wor	kina ı	16b. Kind of Busines	ss/Industry
121	d within giene. r than "	ğ d u	Elementary/Secondary (0-12)	College (1-4or 5	i+)		Ť		NSA	
	77 77 -		17. Father's Name (First, Middle, Las	5+	L.	lectrical E		ne (First Middle i	Maiden Surname)	
Maryland	be do do	To Be	·	ouin				lacEacher		
ary.	E E E	ř	19a. Informant's Name/Relationship		19b.	Mailing Address (Street				e, Zip Code)
	alth a		Ruth H. Thouin	/ Wife	26	526 Salford	Drive Cr	ofton,MD	21114	
ore,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [Bamaval from State	20b. Place of cemeter	Disposition (Name of v, crematory or other pla	ice)		20c. Location - City	or Town, State
Ē			4 □ Donation 5 □ Other (Spec		1	olitan Crem	· Jan.	26,	Alexandri	a,VA
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lie	msee		22. Name and Addre	^{ess of Facility} E Crain Hwy		eral Home ID 20715	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lir	the death. Do n	ot enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a. Suha	lucal	Hema	Dura	hile	Pral	Onset and Death
7	/Medical Examiner		resulting in death)	Due to for as	a consequence o	f):	/	10		11. 49
1		<u>.</u>	Sequentially list conditions,	b. Duranto (or as	a consequence of	0-00	-	1	1	1 ming
	rted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	PA	Laur	ion	D W	1	l	140 eus
,	icate be executed physician and s the burial-transit	Examiner	resulting in death) Last	c. Due to (or as	a consequence o	f):	Word	1 120		June
68760,	te be ysicia e bur			d			W. V.	1,1		
	rtificat ng phy as th	Aedical	IS SERVICE				\mathcal{V}			
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and wage 2 should be detached for use as the burial-transition.	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey		23d. Date of o	delivery Day Year
Δ.	s that ned by	by Ph	Part ther significant conditions	contributing to death b	ut not resulting in	the underlying ca Fe gi	ven i Pirt I.	23e. Did to	bacco use contribute	e to the cause of death?
Records,	w requires been signal should be	ed b	Job anno	et in	win	in all	so fortend	10Y	es 2□No 3□	Probably 4 Unknown
ooe	law re	plet	Tarpini i	ise.		()	V	24a. Was a		autopsy findings available to completion of cause of
Œ.	(0 🖂	Completed	U					perfor		.?
or Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?					th (Check only or	ne)	
or/	this al di	은	1 Nes 2 No	Hospital: 1 Inpatie		patient 3 DOA			ence 6 Other (S	pecify)
no	Ing After une	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending Accident investigation	(Month, Da	<i>y Year)</i> Ir	ijury Wo	iryat irk?]Yes 2⊠No	28d. Describe h	ow injury occurred	
Division	Attending r death. ector: After oy the fune	Certification:	3 Suicide 6 Could not	be 28e. Place of init	ury - At home, far	m, street, factory, office		28f. Location (S	l treet and Number or	Rural Route Number,
Ω̈́	after after Dire	ertil	4 ☐ Homicide determined	building, et	c. (Specify)			City or Tow 2626SA	n, State)	Croston mo.
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical C	29a. Certifier (Check only one) Certifying F Certifying F Check only 2 Medical Example 1	Physician: To the best aminer: On the basis o	of my knowledge f examination and	death occurred at the todor investigation, in my	ime, date and place opinion, death occu	e, and due to the o	ause(s) and manner	as stated.
	To the within To the	Me	29b. Signature and title of certifier	1)		29c. Licen	se number	1	9d. Date signed (Mo	onth, Day, Year)
	/		Multa	Textam		1721	438	1	for 26,2	1007
	0		30. Name and address of person val	completed cause of d	leath (tem 23a) (SE HGHW	An ANA	APOLS	Mnzies	1
		ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1		,		
	Regist	rar	IAN 9 9	2007	2,00 o M	Correct				

			1 - For State Registrar	State of Maryla	-	artment o		-	giene Reg. No 007	02226
			1. Decedent's Name (First, Middle, Last)				•	2. Date of De Month	ath	3. Time of Death
П	Physici /Medio		Irvin	Udoff				JANUAR	Day Year 4 24, 2007	0800 AM
Ĭ.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of De	ath	4c. County of Deatl	1
			MORTHWEST HOSE				dallstown		Baltimon	
	Funeral		5. Social Security Number 6. Sec	IM alle	s. last birthday)	If Under 1 Ye Months Da	sar If Under 24 H ys Hours Mi	n. (Month, Da	th 9. Birth	nplace (State or Foreign untry)
	Director		212-20-7417 X	M 2□F 8	0 Yrs.			03/31/	1926	MD
	and wo		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary	ō	MD BALTIM	ORF	RΛI	TIMORE				1 ☐ Yes 2 ☐ No
	1he	Je C	10e. Street and Number	JIL	DAL	10f. Zip Cod	le		10g. Citizen of What Co	Intry?
	3a or	Funeral Director	7 SLADE AVENUE #	711			21208		•	USA
	ma 2	era		12. Was Decedent Ever in	U.S. 13.	Was Decedent	of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No	14. Race - Ame	ncan Indian,
036	s 1 end 2 should be filed within 72 hours after deeth with the Maryland if Heelih and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28e-f show other traumatic avent, the Mudical Examinar must be notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		If Yes, specify 0 1 □ Yes 200		erto Rican, etc.)	Black, White Specify:	WHITE
P	72 ho	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	cupation		16b. Kind of Business/l	ndustry
21	thin 7	ed.	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	ne during most of w tired)	onking		
2	or the	5		4	INSU	RANCE B	ROKER		INSURANCE	
2	be filed ital Hygid of other avent,	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	, Maiden Sumame)	
<u>X</u>	should bind Ment	2	HARRY		UDO		BERTHA			ISHKIN
Maryland 21215-0036	d 2 sh th and 7 la m traum		19a. Informant's Name/Relationship (Ty PHYLLIS UDOFF / 1		1				er, City or Town, State, Z MORE,MD 212	
ō,	permit. Pages 1 end 3 Depertment of Heelth Important: If Item 27 any Injury or othar tri ance.		20a. Method of Disposition		Place of Diene	cition (Alama of	- Andrews - Company of the Company o	Date	20c. Location - City or	
<u></u>	ages int of t: If If		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State			olace) PARK DIAL ↓01/	20/2007		
altimore,	ertme ertme prten Injur		21. Signature of Funeral Service License						REISTERS1	
B	Depe Impo		1 Roto /	Jan-	_				NSON & BROS. PIKESVILLE	
			23a. Part1. Enter the disease, or compli	cations that caused the de						Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	le cause on each line.						Interval Between Onset and Death
ř	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):					
	Examiner				1 desa					
		Jer	Sequentially list conditions, if any leading to immediate	Due to (or as a cons	equence of):	sire				
V	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď,	a exe lan ar urial-t	Ex	resulting in death) Last	Due to (or as a cons	equence of):					
8760,	cate be executed physician and the burial-transit	dlcal								
9	entific ling p	Mec	IF FEMALE:							
ô n	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1☐Live birth 2☐Fe	etal death 3	Ectopic pregna			23d. Date of delin	very Day Year
P.O. Box	he de the a	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at time o 9⊟Unknown	rdeath 5L	Other (specify	}			-2,
	that the de led by the a detached i	, Ph	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Hecords,	8 50	d b				, ,	-	1 🗆 Y	Yes 2 No 3 Pro	bably 4 XUnknown
ō	w require been si should b	Completed						24a. Was	an 24h Were aut	oosy findings available
e T	he lav e has age 2	mo						autop perfo	osy prior to comed? death?	opsy findings available ompletion of cause of
Vita	ificat or, p	Be C	25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only o		2.6. No
>	ysic s cal	ToB	examiner? 1 ☐ Yes 2√2 No	ospital: 1X Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Other		dence 6 ☐Other (Spec	(6x)
0	Attending Physican: r death. sctor: After this cell flici by the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		njury at Vork?		now injury occurred	97
ğ	ath. r: Ath	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Bay You)	Injury		☐Yes 2☐No	:		
Division of	al or Atte after de 1 Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, offi	се	28f. Location (S City or Tow	Street and Number or Rui vn, State)	al Route Number,
	To the Hospitel or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this cell flicate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best of my ker: On the basis of exami and manner stated.	nowledge, deat nation and/or in	n occurred at the vestigation, in m	e time, date and place by opinion, death occ	ce, and due to the courred at the time.	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signed (Month	Day, Year)
) solt	mo		D	0059736		Janus 2	6 2007
	10		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,		- 2 - (13%		1	
	17		Deboran water				at Hospian	5401	uid court for	
	Sta		31. Date filed (Month, Day, Year)	Fitzgran ca. 32. Aegistrar's Sig	nature	and the				
	Registr	ar	JAN Z J Z	JUI Sulland	1.0 /10	All and				

			1 - For State Registrar	State		nd / Depa		of Healt	th and M	lental Hygi		007	02227
	Physici /Medic		Decedent's Name (First, Middle Wayne	, Last)	Μ.	W	right			2. Date of Death Month	2I ^{Day}	2007°	3. Time of Death 2:37р м
	Examin		4a. Facility Name (If not institution 109 E. 33rd	-	Apt.	l		wn, or Local timore	tion of Death		4c. Co	ounty of Deatl	1
k	Funeral Director		5. Social Security Number 212-74-2757	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs 50		If Under 1 Y Months D	ear If Ur ays Hou	nder 24 Hrs. urs Min.	8. Date of Birth	Ĭ 9 56	9. Birth	nplace (State or Foreign untry) Md.
	aryland ehow	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County Md.	NA	10c. C	ity, Town or Lo	cation 1timore						10d. Inside City Limits Yes 2 \(\text{No} \)
	death with the Maryland rme 23a or 28a-f ehow r roust be notified at	Director	10e. Street and Number				10f. Zip Co			10	g. Citize	n of What Co	
	ne 23a	Funeral C	109 E. 33rd		Apt.			218	c Origin? (Sp	ectiv Yes or No-	USA - 14. Race - American Indian,		
	ours after d ral', or Iten Examiner	þ	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed F	orces? 2 Mo ive	1	f Yes, specify		xican, Puerto	ecify Yes or No- Rican, etc.)		Black, White	
3500-6121	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ariment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural; or iteme 23a or 28a-f show injury or other traumatic event, the Madical Examination relative nothing at a.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 8th grade	t grade completed,) (1-4or 5+)		dent's Usual O kind of work o DO NOT use r USEKEE			ing	6b. Kind	of Business/I	ndustry
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Mar	and 2 sho salth and I n 27 le me er traume		19a. Informant's Name/Relations! Sharon E. Barr		Friend	109	E. 33r	d Str		al Route Number, ot. 1, B			
saitimore,	mit. Pages 1 partment of He portant: If Iten Injury or oth		20a. Method of Disposition 1XX Jurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			Place of Dispo cemetery, crem Mt. Car			1-26			tion - City or 1 alk , Mo	
Dall	permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service	Licensee	ane		Name and A			March F. , Baltim			1202
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that only one cause on	caused the dea	ith. Do not ent	er the mode of	f dying, such	h as cardiac	or respiratory arre	£		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	b	(or as a conse				up - i				<i>FO 7.10</i>
	ate be executed nysicien and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse								
68/6U,	icate be ex physicien s the buria	edicai E		d	(0. 23 2 00130								
C. BOX	w requires that the death certifica been signed by the ettending ph should be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregn birth 2 Fet nant at time of nown	aldeath 3□	Ectopic pregn Other (specif				230	d. Date of deli- Month	very Day Year
ords, P.	requires that sen signed by could be deta	þ	Part II. Other significant condition	ns contributing to c	death but not re	sulting in the ur	nderlying caus	e given in P	Part I.		acco use		the cause of dath?
rai Mecor	The lay	Completed								24a. Was an autopsy perform 1 Yes 2	.	prior to c death?	opsy findings available ompletion of cause of
	Physician: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatien	t 3□ DOA	0		me 5 Resider]Other (Spec	ıfy)
sion o	Attending Pt r death. ector: After th by the funeral		27. Mano r of Death 1 € Natural 5 ☐ Pendin 2 ☐ Accident investig	ation	of Injury oth, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes		28d. Describe ho			
ž Š		Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	286. Plac	e of Injury - At h ling, etc. (Speci	nome, farm, str ify)	eet, factory, of	fice		28f. Location (Str. City or Town,	et and N State)	lumber or Ru	ral Route Number,
	the Hospital hin 24 hours the Funeral upletely filled	edical	29a. Certifier 1 ✓ Certifyin (Check only one)	g Physician: To th Examiner: On the t and mar	e best of my kn casis of examin nner stated.	owledge, death ation and/or inv	occurred at the contract of th	he time, dat my opinion,	te and place, death occurr	and due to the ca ed at the time, da	use(s) an te and pla	id manner as ace, and due	stated. to the cause(s)
	_	Σ	29b. Signature and title of certifier	(Min	e M	D	29c. Li	cense numi	/2	29	d. Date s	igned (Month	Day, Year)
	,}		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	Print)	brill	mal	RI 1	31/	15. N.	1/21210
y S	Sta Registr		31. Date filed (Mohth, Day, Year) JAN 2 9	2007	Registrar's Sign	ature	uli)	- u/i		P			

			1 _ State	e of Marylar		artment of F rtificate of				- /	107	02228
W	- ·		Registrar 1. Decedent's Name (First, Middle, Last)		001	tilleate of	Dean		Date of Dea			3. Time of Death
U	Physicia		Marion		W	lliamson		1	Month nuary	24, 2	2007	8:30 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street an	d number)		4b. City, Town, o	r Location	n of Death			unty of Death	
		de P	1700 DeKalb Court			Hyatts					ince Ge	
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2X	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min. (Date of Birth Month, Day	, Year)	Cour	
Jerge	Director		579-40-0864 Usual Residence of Decedent	91	113.			0c	t. 30	, 191	5 Vir	ginia
	yland now at		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	e Mar ta-fsl	ctor	Maryland Prince George	's Hy	attsvil	le						1 ☐ Yes 2 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			1	10g. Citizen	of What Cour	ntry?
	s 23a	eral	1700 DeKald Court	Decedent Ever in U	10 40	20782	liana de C	2 / 1 - 10 / 10 14 -		J.S.A.	Race - Americ	on Indian
	fter de r item iner r	Funeral	1 Never Married 2 Married 1 1	d Forces? ′es 2.⊠No	7.5.	Was Decedent of H If Yes, specify Cub	an, Mexic	can, Puerto Rica	n, etc.)	14.	Black, White,	
036	rai", o	by	_ li Ye	s, Give ** or Dates:		1 ☐ Yes 2 🎇 No	Specif	fy:		Sp	ecify: Bla	ıck
2	72 hc 'natuı di al	eted	15. Decedent's Education (Specify only highest grade comple	ted)	(Give	dent's Usual Occup kind of work done	durina ma	ost of working		16b. Kind o	of Business/Inc	dustry
121	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	life.	DO NOT use retired Sales	al)	-		Reta	. . 1	
d 2	filed Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)			bates	18. Mot	ther's Name <i>(Fir</i>	st, Middle,			
an	lid be lental ked c	To Be	Samuel Hunter, Sr.				Mo	llie El	liott			
ary	2 should be filled w and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relationship (Type. Print	1	19b. Mailir	ng Address (Street				r, City or To	wn, State, Zip	Code)
Σ.	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			hew)		DeKalb C			ille,			
ore	Pages 1 nent of H int; If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	rom State	Place of Dispo cemetery, crei	sition (Name of matory or other plac	ce)	Date		20c. Locati	on - City or To	own, State
Baltimore, Maryland 21215-0036	it. Par rtmen rtant; njury		4 Donation 5 Other (Specify)	St		Cemetery		2/3/07		Brook	kneal,	VA
Ba	permit. Pag Department important; I any Injury o		21. Signatule of Funeral Service Licensee	4		Name and Addre					- 0.0	
	2205		23a. Part1. Enter the disease, or complications is shock, or heart failure. List only one cause	hat caused the dea		er the mode of dyir					528	Approximate
	Physician		Immediate Cause (Final	theroscle								Interval Between Onset and Death
1	/Medical		resulting in death)	e to (or as a conse		cardiovas	SCUIA	il neart	DISE	ase		-
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₹ }	ted	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	e to (r as a conso	quenna arir							
7	be executed sician and burial-transit	Examiner	that initiated events c.	e to (or as a conse	quence of):		-					
68760,	ficate be executed physician and is the burial-transit	edical	d									
			IF FEMALE:									
Box	leath certifi attending I for use as	Physician/M	23b. Was decedent pregnant 23c. If yes	, outcome pf pregr live birth 2 ☐ Fet	al death 3	_ Ectopic pregnanc;	у			23d.	Date of delive	ery Day Year
0	he de the a	ysic	1 Vac 2 1 No 4 U	regriant at time of Inknown	death 5	Other (specify) _					WOTE	Day Tour
Д.	The law requires that the death cert ite has been signed by the attending agge 2 should be detached for use a		Part II. Other significant conditions contributing	to death but not re	sulting in the u	nderlying cause giv	en in Par	rt I.	23e. Did to	bacco use	contribute to the	ne cause of death?
rds	quires in sign uld be	ed by							1 □ Y	es 2□N	lo 3□ Prob	oably 4 🖄 Unknown
ဝ္ပ	aw require ts been si 2 should b	Completed						ľ	24a. Was a	in 2	4b. Were auto	psy findings available
ř		E O							autop: perfor 1∐ Yes	med?	death?	mpletion of cause of 2 ☐ No
Vital Records,	Physician: The law this certificate has k ral director, page 2 s	Be (25. Was case referred to medical examiner?			Tou.		ace of Death (Ch	eck only or	ne)	-	
	Physic this crall direct	. To	1 ∑ Yes 2 No Hospital: 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ Date of Injury	ER/Outpatier 28b. Time o		4□!	Nursing Home	5 X Resid			y)
on	Attending Physician: r death. ector: After this certifics by the funeral director, I	tion		Month, Day Year)	Injury	Wor	rk? Yes 2[Describe III	ow injury oc	coned	
Division or	or Attend after death. Director.	ifica	3 Suicide 6 Could not be determined 28e.	Place of injury - At houlding, etc. (Spec	nome, farm, sti	reet, factory, office					umber or Rura	al Route Number,
5	ital or rs afte ral Dir lec in	Certification:	T I TOTAL CO	Janaing, etc. (Opec					City or Tow	n, state)		
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 ☐ Certifying Physician: 1	the basis of examin	owledge, deat ation and/or in	h occurred at the ti	me, date opinion, d	and place, and leath occurred a	due to the o	ause(s) and date and pla	d manner as s ace, and due to	tated. o the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	manner stated.		29c. Licens	se numbe	r		29d. Date si	gned (Month,	Dav. Year)
	⊢≯⊢ŏ		I Salvador A	Posto	Do	K	100	5742			-	
L	27		30. Name and address of person who completed	cause of death (Ite	m 23a) (Type,	Print)				3 -770	7	7
	11		SALVAdor Sy/rest	-en 300	× Ho	pital.	Dry-	re, CG	aver	8,1	Cright 1	6, 200)
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Sigr	nature			,	2	//	0	
	negisti	aı	JAN 2 9 2007 J	religious filtrand at	and the same	19-01						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AND TIPM 17 per INF. 984-2/15/07 WS
State of Maryland / Department of Health and Mental Hygiene) 17 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time 3 32th **Physician** White Geraldine /Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Dea **Examiner** | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Must | Min. | Must | Min. | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must | Must Baltimore LEVINDALE 7. Age (In yrs. last birthday)
70 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 1□M 20F Months 215-30-5980 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The state 12 is marked other than "natural", or items 23a or 28a-f show ans. If item 27 is marked other than "natural", or other treumalic event, ins Magical Examiner must be notified at ury or other treumalic event, ins Magical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Mo 1 Yes 2 □ No Completed by Funeral Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4743 Heights Ave

12. Was Decedent Ever in U.S.
Armed Forces?

1 | Yes 2 | No
If Yes, Give
Year or Dates: 21215 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Smott awa House 17. Father's Name (First, Middle, Last)

BRAXTON 18. Mother's Name (First, Middle, Majden Surname) Be Leroy hebecca ပ (layle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) White 4743 Park Heights Reginald. Ave Baltimore Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal Irom State permit. Page Depertment of Importent: If any injury or once. Mt Zion 4 Donation 5 Other (Specify) Comeberry 29/07 Landowne 22. Name and Address of Facility ("hatman - Hacris" 21. Signature of Funeral Service Licensee FUNECUI Home Pro 5240 Preisters your Rd Baltimore Ma 2125 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician REMAL ACUTE FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRONIC KESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician end hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical requires that the death certi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9☐ Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. bete has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ CHRONIC RENAL INSUFFICIENCY Be Completed 1 Yes 2 No 3 Probably 4 Unknown certificete has been CHRONIC OBSTRUCTIVE DULMONARY 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No Hospitel or Attending Physician: funeral director. 25. Was case relerred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter to the Funeral Direct 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jan. 24, 2007 D0063327 Carson H. WODERTOWOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 GIZAW WOLDEHIWOT BELVEDERE AVE WEST BALTIMORE, MD 21215 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2007

ital Records, P.O. Box 68760, American Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Donard of Houlth and Maryal Burgings	Department or results and when the process of them 23a or 28a-f end important; I flem 27 is marked other than "natural; or flem 23a or 28a-f end eny injury or other treumatic event, the Madical Examinat must be notified a	0000
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ecords, P.O. Box 68760,	an: The law requires that the death certificate be executed	rificete hes been signed by the ettending physician and stor, page 2 should be detached for use as the burial-transit	

			1 - For State Registrar	State of Marylan	-	artment of F tificate of		R	eg. No.		See Nove State 14
	Physici /Medio		Decedent's Name (First, Middle, Last) MILDRED			WILDER		2. Date of Deat Month JANUARY	Day 20	Year 07	3. Time of Death 11:45 P M
	Examir Funeral Director		4a. Facility Name (If not institution, give s 1 POMONA EAST AP* 5. Social Security Number 6. Sex 127-48-7518	Г. #403	last birthday) Yrs.	4b. City, Town, o BALTIN If Under 1 Year Months Days		8. Date of Birth (Month, Day, 09/02/19	В	y of Death ALTIM 9. Birth	
		ctor	Usual Residence of Decedent	10c. Cit	y, Town or Lo	cation IMORE		ψ <i>57 027</i> 13	11		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland me 23a or 28a-f ehow ricust Le netified at	rai Director	10e. Street and Number 1 POMONA EAST APT			10f. Zip Code 21208			0g. Citizen of	Α	•
200	or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I □ Yes 2 1 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		ck, White,	
7.01717	withir iene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	DO NOT use retired	during most of work	king	16b. Kind of E	Business/In	•
/land	uid be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last)		RUBIN		18. Mother's Nam Minnie MINNE	ne (First, Middle, I	Maiden Suma	^{me)} SUGA	AR.
e, Mar	s 1 and 2 should if Health and Mer tiem 27 is marks other treumatic		19a. Informant's Name/Relationship (Ty, ANDREA L. DENICK 20a. Method of Disposition	/ DAUGHTER	1312		and Number or Rur	E - BALT	IMORE,	MD 2	21208
пппог	t. Page rtment o rtant: If njury or		Surial 2 Cremation 3 R	lemoval from State BAL	TIMORE	HEBREW C	ONG. 01/2	26/2007		ERSTO	WN, MD
ם ח	Depa impo eny i		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	Cottons that caused the deat	8	900 REIS	SO TERSTOWN	L LEVINS ROAD - P or respiratory arri	IKESVI	ROS., LLE,	INC. MD 21208 Approximate Interval Between
/ '00/8	Physician /Medical Examiner bubsician and butaintensit steep phical transit ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of): uence of):	IC CAI	REENOMA	UNKNO	wal (R	ch Ar/	Onset and Death	
O. Box o	death certified e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknowy	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy	1			ate of deliv	ery Day Year
cords, P	w requires that the de: been signed by the e should be detached f	ρ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did tot		ntribute to t	the cause of death? bably 4 □Unknown
Ital Hec	The law ete hes b page 2 sl	e Completed	25. Was case referred to medical				00 81 40		med?	Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
DIVISION OF VI	ng Phys fter this ineral di	Certification: To B	examiner?	1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At h. building, etc. (Specif	ER/Outpatien 28b. Time of Injury ome, farm, str	28c. Injur Wor M 1	ner: 4 ☐ Nursing Ho	28d. Describe ho	once 6 □Ot ow injury occu	rred	fy) al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier Check only one) Certifying Physical Examination	isician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death	occurred at the tire vestigation, in my o	me, date and place, opinion, death occur	and due to the carred at the time, d	ause(s) and mate and place	anner as s , and due t	itated. o the cause(s)
	with:	M	29b. Signature and title of certifier		22.1	29c. Licens			9d. Date sign	ed (Month,	Day, Year)
	(e Sta		30. Name and address of 2 rson who co	empleted cause of death (Item 200 32. Registrar's Signa	Qu ARA	erint) LY LAKE	9317 EDR, BA	HUTTO	10RE,	MD	21209
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			for State Registrar	State of Marylar		artment of F rtificate of			iene _{9. No} 2 0 0 7	02231
	Physici /Medic		1. Decedent's Name (First, Middle, La Mary Zac	sharchuk				2. Date of Deat Month January	Day Year	3. Time of Death 7 2:25 P.M
	Examin		4a. Facility Name (If not institution, gir Nichols Shelte 5. Social Security Number 6.		. (ast birthdav)	4b. City, Town, o	ar Location of Death	8. Date of Birth	4c. County of Dea	d
	Funeral Director		213-18-1356 Usual Residence of Decedent	1□M 2½F 86	Yrs.	Months Days	Hours Min.	March I	,1920 Ma	rthplace (State or Foreign ountry) aryland
	Maryland	tor	10a. State 10b. County Md. Harf		Falls					10d. Inside City Limits 1 ☐ Yes 2 No
	deeth with the Maryland ms 23e or 28e-f ehow r must be notified at	Funeral Director	10e. Street and Number 2047 Durham Ro	ad		10f. Zip Code 21 ()47	1	0g. Citizen of What C	ountry?
0000	72 hours after deeth with the Marylan *naturel; or Items 23e or 28e-f ehow sidical Exacultar must be notified at	by Funer	11. Marital Status 1 ঐNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	†	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:	
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yland z	be filed ital Hygi id other event, I	To Be Co	17. Father's Name (First, Middle, Las Theodore Zacha		Tay	/10]]/16	18. Mother's Nan	ne (First, Middle, M Pesarch	Maiden Sumame)	enc Dank
baltimore, mary	permit. Pages 1 and 2 should Depertment of Health and Men Important: if Item 27 ie marke eny Injury or other traumatic. <u>QDCB</u> .		19a. Informant's Name/Relationship W.Richard Kota 20a. Method of Disposition 1图 Burial 2□Cremation 3 (4□Donation 5□Other (Spec	senski/nepho	ew 204 Place of Dispo cemetery, creat t.Mich	7 Durha position (Name of matory or other plan naelUk.C	m Road Cem. 1-2	Fallsto Date 27-07 E	20c. Location · City o Baltimore	21047 rTown, State e, Maryland
Dan	permit Depert Import eny inj		21. Signature of Funeral S. No. Lice	lace	1	201 Dun	dalk Av	e. Balt	imore, M	I Home,PA
*	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disea e, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to aminously cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Let of the consect of	sis equence of): e lits ouence of): to H	ler the mode of dyn	ng, such as cardiac	correspiratory arre	sst,	Approximate Interval Between Onset and Death
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1	e		30. Name and address of person who Stephanie		om 23a) (Type 102 A	Print) Verill R	d Jo	ppa, n	10 210	25, 2007 085
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			1_ For State	State of Marylan	0		Mental Hygien	^e 2007 02232
Am	end ite		Registrar#2 per DR/w 1. Decedent's Name (First, Middle, Las	"	10	te of Death	2. Date of Death Month	
· A	Physicia /Medic	ai	EUELYN	JONES		LEN	0	07 8,251
*	Examin	er	4a. Facility Name (If not institution, give	ring + Rehab	Ctr. Sn	7, Town, or Location of Deat		OCCUPTION OF DEATH
	Funeral Director		517-14-1562	7. Age (In yrs. 95	/ast birthday) If Und Months	er 1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Aaryland I ehow	or	Usual Residence of Decedent 10a. State 10b. County	1 5.	ty, Town or Location	1		10d. Inside City Limits 1
	or 28e-i	Funeral Director	10e. Street and Number	3.tc- 131	101. Z	ip Code	10g. C	itizen of What Country?
	deeth w	erai	412 COUINGT	12. Was Decedent Ever in U	S. 13. Was Dec	2 X 6 3 edent of Hispanic Origin? (S	Specify Yes or No-	U. S. A. 14. Race - American Indian,
920	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Itam 27 ie marked other then "neturel; or Iteme 23e or 28e-f ehow other traumatic event, the Mudical Expoling round be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	If Yes, sp 1 □ Yes	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 2002 No Specify:	to Rican, etc.)	Black, White, etc. Specify: R / Cuc / C
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Man	od 2 shoulith and Mariant		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addres	ss (Street and Number or R	1 1011	1 A 10000
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Baltimore	t. Partmer		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen:	lin lin	rdlys Chu	200 1-2 Id Address of Facility 0	0-07 Po	comoke Md.
Ä	Depe Impo		my Le Su	ill	P.O.	BUX 331	POLONOKE	ith fun cral Home mo. 21851
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Box 6	h certifica anding pl use as t	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		125		23d. Date of delivery
P.O. B	res thet the death certific igned by the ettending p be detached for use as	Physician/Med	in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown				Month Day Year
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Division of Vital Records,	To the Hoepital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto	1 ☐ Yes 2 ☐ No	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number,
Ω	epital o		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, death occurred	d at the time, date and place	and due to the cause/s	c) and manner as stated
	the Ho iin 24 I the Fu	Medical	one)	iner: On the basis of examina and manner stated.	ition and/or investigatio	n, in my opinion, death occi	urred at the time, date an	d place, and due to the cause(s)
	To with	-	29b. Signature and title of certifier	mi)		0c. License number 0 0062172		ate signed (Month, Day, Year)
	200		30. Name and address of person who co					MD 21851.
2	Sta Registr		31. Date filed (Month, Day, Year)	32. A sistrar's Signa	ature			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2007 Richard Clarence BOWERS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 1 M 2 □ F 1920 86 Sept. Maryland 219-05-5262 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Maryland Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 1440 S. Potomac Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black White etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WW II 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) metal works foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Bell Green is marked Roy Cleggett Bowers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:3
Department of Health at Important: If Item 27 is any injury or other trau 1440 S. Potomac Street, Hagerstown, Md. 21740 Helen A. Bowers - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/2007 Rose Hill Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 hour **Physician** disease or condition resulting in death) /Medical hemi tar Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year signed by the atte in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy 2 No 1 ☐Yes 2 ELM To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Thipatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To this 27. Manuar of Death 28d. Describe how injury occurred Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5H8+1 32. Registrar's Signature 31. Date filed (Month, Day, State Registra

	State of	of Maryland / D	epartment of F C <i>ertificate of</i>		ental Hygie Reg.	2007	7 02234
Physician	Decedent's Name (First, Middle, Last)			2	2. Dete of Deeth Month	Dev Yea	3. Time of Death
/Medical	Evelyn Mary BARNHART				January 1	14, 2007	10:30 p.m.
Examiner	4a Facility Neme (If not institution, give street and no	umber)		4b. City, Town, or Loca		4c. County of De	
	North Hampton Manor 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year	Freder	LCK B. Date of Birth	Frede	
Funeral Director	217-42-8331 1□ M 2\ F	100 Y	Months Days	Hours Min.	Jan. 2,		linthplace (State or Foreign Country) ryland
natural; or items 23a or 28a-f show fical Examiner must be notified at sted by Funeral Director	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
28a-1 show notified at rector	Maryland Frederick	Mi	ddletown				1 □ Yes 21 No
be notified Director	10e. Street and Number		10f. Zip Code	·	10g.	Citizen of What	Country?
를 물	2602 Bennies Hill Road		2170	69		USA	
Examiner must	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dec Armed F 1 Never Married 1 Never Married 12. Was Dec Armed F 1 Never Married 12. Was Dec Armed F 1 Never Married 12. Was Dec Armed F 1 Never Married 12. Was Dec Armed F 1 Never Married 12. Was Dec Armed F	cedent Ever in U,S. orces? 2 (A) No ive Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕅 No		ify Yes or No- ican, etc.)	14. Race - Ar Black, Wi Specify: V	
other than "nature event, the Medical event, the Medical Be Completed	15. Decedent's Education (Specify only highest grade completed)	16e. E	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of working	16b	. Kind of Busines	ss/Industry
i de		(1-4or 5+)	iile. <i>DO NOT</i> use retire omemaker	d)		how arm	h o
J. C	17. Fether's Name (First, Middle, Last)	11	Omemaker	18. Mother's Name (First, Middle, Maid	her own	nome
traumatic event,	Richard Rummel				e Louder		
	19a. informant's Name/Relationship (Type, Print)	19b. I	Mailing Address (Street	L _			, Zip Code)
er tra	Eugene W. Barnhart - so	on 2	602 Bennies	s Hill Rd.,	, Middlet	cown, Md	. 21769
orant: if item 2. injury or other is.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Broadf	Disposition (Name of crematory or other pla Ording Bib. en Cemetery	le 1,		Location - City of	or Town, State wn, Maryland
important: If any injury or once.	21. Signature of Funeral Service Licensee	nama (22. Name and Address 4.15 E. Wil	ss of Facility MIN lson Blvd.,	NNICH FUN Hagerst		
	23a. Pert1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do ac	enter the mode of dying	ng, such es cardiac or	respiratory arrest,		Approximate Interval Between
sician edical miner	Immediate Ceuse (Final disease or condition resulting in death) a.	Myocardi	of Info	evetion of fair			Deugs
e e		Due to (or as a co	ensequence of):	1- F	/		
in and fal-transit Examiner	Secure the list see divises	onger m	nsequence of):	of Tan	inc		Berg
is the burial-transit edical Examir	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co					
D 6	resulting in death) Last	Due to (or as a co	пзециенсе од.				
ed for	Part II. Other significant conditions contributing to d	leath but not resulting in t	he underlying cause giv	ven in Part I.	23b. Did tobac	co use contribu	ite to the cause of death?
Phy	No. L.	•			1 ☐ Yes	W	Probably 4 Unknown
b ed	Humper						
ate has been signed by me arending, page 2 should be datached for usa a completed by Physician/Me					24a. Was an au performed		b. Were autopsy findings available prior to completion of cause of deeth?
rthis cartificate has bring director, page 2 s					1 □ Yes	2.X No	1 ☐ Yes 2 ☐ No
Be C	25. Was case referred to medical examiner?			26. Place of Death (Check only one)		
	1 ☐ Yes 2 No Hospital: 1 ☐	Inpatient 2 ER/Outp		4 EL Nursing Home	9 5 ☐ Residence	6 □Other (Sp	pecily)
e funera ation:	27. Menner of Death 1 XNatural 5 Pending 2 Accident investigation	of Injury 28b. Tir nth, Day Year) Inju	ury Wo		d. Describe how in		_
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Please build	e of Injury - At home, farn ing, etc. (Specify)	n, street, factory, office	28	f. Location (Street City or Town, St	t and Number or i tate)	Rural Route Number,
completely filled in by the funeral di	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the band man	best of my knowledge, obasis of examinetion end/ ener stated.	deeth occurred at the tir or investigation, in my o	me, date and place, an pinion, death occurred	d due to the cause I at the time, date a	e(s) and manner and place, and d	as steted. ue to the cause(s)
W Comb	29b. Signature end title of certifier		29c. Licens	4309/	29d.	Date signed (Mo	
0	30. Name and address of person who completed caused and	- 4 - 4	ype, Print)	TOLL HO	use Ar	M. Pr	rederak
State Registrar	31. Date filed (Month, Day, Year) 32. F JAN 18 2007	Registrar's Signature	Sperks			, , , , , , , , , , , , , , , , , , , 	MM
Product Indiana							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 17 For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician January 6 2007 Esther Bagwell 2320 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Millersville Anne Arundel 230 Dogwood Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🔽 F 69 Yrs. Director 219-34-3734 Dec 16 1937 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Iteme 23a or 28e-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Anne Arundel Millersville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 Dogwood Rd. 21108 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ▼ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packer Potatoe Chip Co. 11th 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Oscar Collins Ethel Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Persaud(Daughter) 230 Dogwood Rd. Millersville, Md. 21108 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Glen Haven Cemetery 1-11-07 Glen Burnie, Md. 21. Signature of Funeral Service Licenses ₩mane Redese of & collisons Mortuary, P.A. Zavory B. Reese Moo483 821 West St. Annapolis,

23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause pleach line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Cordiv Vas alar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit l or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 9 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral di 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) deBorp, m.D 3708 mountain hristopher Aegistrar's Signature 31. Date filed (Mo 1 1 2007 State Registrar

			1 - For State Registrar	State	of Maryl		artment of I rtificate of		d Menta	al Hygien	2001	022	237
			Decedent's Name (First, Middle,	Last)						e of Death		3. Time o	of Death
	Physici		Richard Allan Ba	ates, Jr					1 Mo	nth D	200		РМ
	/Medic Examin		4a. Facifity Name (If not institution,			**	4b. City, Town,	or Location of De	ath		c. County of Dea		
	Exami		2385 Fairmount B	Peo S			Hampste	Dec		-	Carroll		
	Funeral			S. Sex	7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 H	lrs. 8. Dat	e of Birth onth, Day, Yea		rthplace (State	or Foreign
	Director		219-58-5662	1 № M 2□ F	5	4 Yrs.	Months Days	Hours M		onth, Day, Yea 20/1952		ountry)	
	D		Usual Residence of Decedent			10				.0/ 1952	IMal	cyland	
	nylan how		10a. State 10b. County		10c	. City, Town or L	ocation					10d. Inside C	lity Limits
	a-1-a	Director	MD Carro	Ll	H	ampstead	d					1 🗋 Yes	2 ∑ No
	7 28	ire	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	ountry?	
	th wi	ai	2385 Fairmount B	Road			21074			Uni	ted Stat	es	
	dea E	ner	11. Maritaf Status		cedent Ever	in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Ye	s or No-	14. Race - Am	erican Indian,	
9	or Ite	by Funerai	1 ☐ Never Married 2 ☐ Marrie		2 🖵 No				ento racan,	610.)	Black, Wh		
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رم م	within 72 hours after death with the Maryland ene. then "naturel", or lieme 23e or 28e-f ehow he Madical Exeminer must be notified at	Completed	15. Decedent's (Specify only highest)	(Give	dent's Usual Occu	during most of w	vorkina	16b.	Kind of Business	s/Industry	
7	or Wa	idu	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	ed)					
	ygier ygier t.	Ö		2		Lab 1	lech.				ate High	way Adr	nin.
밑	be fill d oth	Be	17. Father's Name (First, Middle, L.					18. Mother's N	lame (First,	Middle, Maide	on Sumame)		
<u>×</u>	Men Men arke	၉	Richard Allan Ba	ates, Sr	•			Gloria					
Maryland	2 sh and le m	18	19a, Informant's Name/Relationshi				ng Address (Stree						
	end eelth n 27		Carol Joyce Chal	k Bates				t Road,		tead, 1	MD 21074	<u> </u>	
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or iteme 23a or 28a-1 show way injury or other traumatic event, the Madical Examinat must be notified at anone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	B □Removal from		b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c.	Location - City o	r Town, State	
Ē	Pag ment ent: ury c	1	4 □ Donation 5 □ Other (Spe			Carroll	Crematio	n 1/1	15/200	7 Ham	stead.	MD	
<u>=</u>	Depart Import eny Inj		21. Signature of Funeral Service Li	censee		2	2. Name and Addr	ess of Facility	Eline	Funera	l Home,	934 Soi	ıth
ш_	20159		Steven W	J. Elin	· M	00723 N	Main Stre						
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	ompfications that	caused the c	leath. Do not en	ter the mode of dy	ing, such as card	ac or respin	ratory arrest,		Approxima Intervat Be	te tween
	Physician		Immediate Cause (Final disease or condition	G	rrhos	212	f liner	~				Marvu U	Death
	/Medical		resulting in death)	Due to		sequence of):	ILLUXY					That you	jacos
	Examiner		Sequentially list conditions,	b. He	patil	is C							
	p #	ner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a con	sequence of):							
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Ö,	e exe lan e urial-	E	resufting in death) Last	Due to	(or as a con	sequence of):							
8760,	ficate be executed physician end s the burial-transit	dicai	1.1	d									
9	ing p	Mec	IF FEMALE:			75 25							
ဓ္ဏ	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, or 1□Live	utcome of pre birth 2 1		Ectopic pregnanc	y			23d. Date of de		W
Division of Vital Records, P.O. Box	e deg	Sic	1 Yes 2 No	4☐Preg 9☐Unki	nant at time	of death 5	Other (specify)				Month	Day	Year
<u>~</u>	The law requires thet the death certifi sie hes been signed by the ettending age 2 should be deteched for use a	Physician/Me	-										
<u>'</u>	igne bed	۵	Part II. Dther significant condition	s contributing to	death but not	resulting in the u	nderlying cause gr	ven in Part I.	23		use contribute (
0.0	w requir been si should	ted							-	1 Z Yes	2 □ No 3 □ P	robably 4 🗌	Unknown
e C	elaw hesb	pie							24	a. Was an autopsy	24b. Were a	utopsy findings completion of	avaitable
<u> </u>		Completed							10	performed? Yes 2 (28)	death?	s 2 No	
<u>=</u>	Attending Physician: The death. ector: After this certificete by the funeral director, pag	Be (25. Was case referred to medicat examiner?					26. Place of D	eath (Chec				
<u>~</u>	Physical this call dire	ဥ	1 ☐ Yes 2 No	Hospital:	Inpatient	2 ER/Outpatie	nt 3□ DOA Ot	her: 4 \(\text{Nursing}	Home 5	Residence	6 ☐Other (Spe	ecify)	
_	ding P h. After t funera	on:	27. Manner of Death 1 ☑Ñaturat 5 ☐ Pending	28a. Date (Moi	of Injury oth, Day Yea	28b. Time of Injury	f 28c. Inju	ry at ork?	28d. De	scribe how in	ury occurred		
<u> </u>	tendi Jeath. tor: A the fu	cati	2 ☐ Accident investiga	tion			M 1	Yes 2 □No					
Ξ	l or Atten efter deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed Zee. Flau	e of Injury - A	At home, farm, st ecify)	reet, factory, office		28f. Loc City	cation (Street a	and Number or F te)	lural Route Nun	nber,
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	Hosp 4 hou Fune ely fi	cal	Check only 2 Medical E	Physician: To the caminer: On the	e best of my	knowledge, deat nination and/or in	h occurred at the t vestigation, in my	me, date and pla	ice, and due	to the cause(s) and manner a	s stated.	(2)
	To the Hospital or At within 24 hours effer of To the Funerel Direct completely filled in by	Medical	<i>G</i> 1107	and mai	nner stated.								
	S T S S	_	29b. Signature and title of certifier	~			29c. Licen	se number		29d. D	ate signed (Mon	កេ, Day, Year)	
•	4151		(ADOCHA)	V			103	0116		1-	16-04	-	
	10		30. Name and address of person w	ho completed cau	se of death (1.	71797			
			31. Date filed (Month, Day, Year)	scha, M.	N. 43		thwaxes	Irail F	Tamp	stad	MD à	1074	
	Sta Registr	_	JAN 1 6	2007	Registrar's S	ignature	Nº 40						
	3.0.		JAIN T	6001	THE WAR	1 11. 1	MIRANI J						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January **Physician** 14, 2007 12:45 pm Edith Laura Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Center Examiner Carroll Westminster Westminster Nursing & Rehabilitative 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 22, 1915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 91 172-10-9153 Yrs. Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at Maryland Carroll Westminster 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 122 Lippy Avenue USA filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 2 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Office Secretary 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be nent of Health and Mental Daniel Decker Annie Ratcliffe ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Lippy Avenue, Westminster, MD 21157 f Health if Hem 27 i other tra Ida May Muller, daughter 20b. Place of Disposition (Name of complete, crematory or other place)
South
Carroll Crematory 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Important: If Ite
eny injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1/19/2007 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Myers-Durboraw Funeral Home M01191 91 Willis Street, Westminster, MD 21157 maron 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arteriose **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the all 4 Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete hes t lirector, page 2 s perform 2 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours af To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Wolflitm MD W25443 WIZ Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 688 Paole KA, Wybanister MD 2/157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1 - State of M	aryland / I		rtment of F tificate of		Mental Hy		000	7 00000
			Registrar 1. Decedent's Name (First, Middle, Last)			inoate or	Douin	2. Date of D	Reg. No	. 200	3. Time of Death
	Physicia		Robert C. Bonney					Month Januar	y 9		3:35 P. ^M
je.	/Medic Examin		4a. Facility Name (If not institution, give street and number,)		4b. City, Town, o	r Location of Dea			. County of Dea	
<i>)</i>			Citizens Care and Rehabilit	ation C	ente	r Fred	lerick			Frede	
	Funeral Director			ge (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year,	9. Bir 1922 P	thplace (State or Foreign buntry) ennsylvania
	pu: N		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Loc	ration					10d. Inside City Limits
	faryla shoved at	ō	,								1 ☐ Yes 2 🖾 No
	the N 28a-i notifi	rect	Maryland Frederick 10e. Street and Number	Walker	LSVI	10f. Zip Code			10a. Ci	tizen of What Co	ountry?
	3a or st be	<u>=</u>	9524 Stauffer Road			21793			US	SA	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tier Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Was Decedent Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	? [No		Vas Decedent of H Yes, specify Cub ☐ Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, Whit	
5-0036	2 hour latural' ical Ex		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		a. Deced	ent's Usual Occup	oation	a elvin a	16b. k	(ind of Business	/Industry
7	Ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12) College (1-4or	5+)		kind of work done O NOT use retired					
Z	led wl lygier her th	S	2	Sta	anda	rds Admi				er plant	
land	t be fil intal H ed ott	Be	17. Father's Name (<i>First, Middle, Last</i>) Milton Bonney				Gladys	me <i>(First, Middl</i> P1ace	е, маюе	n Surname)	
	should nd Me mark matic	ဍ	19a. Informant's Name/Relationship (Type. Print)	19	b. Mailine	g Address (Street			ber, City	or Town, State,	Zip Code)
Z	nd 2 sailth ar		Roberta Jones - Daughter	74	443	Watermar	k Drive,	Allenda	ale,	Michiga	ın 49401
ē,	ss 1 a of Hea item		20a. Method of Disposition	comete	of Dispos	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or	Town, State
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Stauf	fer	Cremator	y 1-13	3-2007	Fre	ederick,	Maryland
Baitimore,	permit. Departi Importa any Inj		21. Signature of Funeral Service Licensee	Eline		Name and Addre		tauffer ike, Fre			
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do	not ente	er the mode of dyir	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	g s a consequence		ulin)	Llisa	se			Onset and Death
	Examiner	L	Sequentially list conditions, b.								
	ted sit	Examiner	rativ, leading to Introduct cause. Enter Underlying Cause (Disease or injury that initiated events	s a cutal quence	i oty:						
,	icate be executed physician and s the burial-transit	zxar	that initiated events resulting in death) Last C Due to (or as	s a consequence	of):		. , , , , , , , , , , , , , , , , , , ,				
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9	rtifical ng phy as th	/ledi	IF FEMALE:								
POX	death certif e attending id for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?	e pf pregnancy 2 ☐ Fetal deat at time of death		Ectopic pregnanc	У			23d. Date of de Month	elivery Day Year
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rds, r	w requires that the death certific been signed by the attending p should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tot 1 Telephone						1	bacco use contribute to the cause of death? 'es 2 No 3 Probably 4 □Unknown	
Hecord	law red as bee 2 shou	Completed						24a. Wa			utopsy findings available
	<u>ө</u>	mo							opsy formed? 2 2 N	death?	completion of cause of
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					eath (Check only	/-		
or	Physician: this certific ral director,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpat			3 DOA		Home 5□Res			ecify)
ono	iding Physith.	tion:	27. Manner o Teath 1		Time of Injury	28c. Injui Wor M 1 □	ryat rk? Yes 2 ∐ No	28d. Describe	how inju	iry occurred	
DIVISION	I or Atter after deal Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of in	njury - At home, f etc. <i>(Specify)</i>	arm, stre	eet, factory, office		28f. Location City or To	(Street a own, Stat	nd Number or R e)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the basis and manner s	of examination a	ge, death ind/or inv	occurred at the tivestigation, in my	me, date and plac opinion, death oc	ce, and due to th	e cause(s	s) and manner and place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	•		29c. Licens	e number		29d. Da	ate signed (Mon	th, Day, Year)
	à		X Mold, Kerfm	en		10-	13971		11	10/0	7
	V		30. Name and address of person who completed cause of						1	-	
	Cto	to	Robert L. Kaufmann / 32 degist	300 We trar's Signature	est 1	Ninth Sti	reet, Fr	ederick,	Mar	yland	21701
	Sta Registr		IAN 1 6 2007	-	1	ach's					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 18, 2007 4:00 A M Roy Willard Bittinger /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5708 Amish Rd. Grantsville Garrett H Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 31, 1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**∑**M 2□ F 80 Yrs. 212-24-1526 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2X No Directo Garrett Grantsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 death with 5708 Amish Rd. 21536 USA or items 23a Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 ₩Widowed 4 Divorced White "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Trucking 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Int. If item 27 te marked of Norman L. bittinger Pearl C. Fazenbaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5857 Amish Rd., Grantsville, MD Larry D. Bittinger/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility Newman Funer
P.O. Box 275, Grantsville, M.

23a. Part. Entey the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death)

a. WENKEL Bittinger Cemetery Jan. 21, 2007 Bittinger, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 Approximate Interval Between Onset and Death 2000 Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yas 2 ☐ No 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page 2. No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 2Bb. Time of 2Bd. Describe how injury occurred Certification: After Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be 2Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daviol Milher 691 Welf 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 9 JAN 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:30 A M 15, 2007 January Burdock Rosemary 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Garrett Dennett Road Manor Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 8. Date of Birth (Month, Day, Year) July 11 1917 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 🛱 F 216-22-5716 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ty Yes 2 □ No 0akland Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21550 United States 1113 Mary Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Gross Clarence F. Rollman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21 N. Second Street, Oakland, MD 21550 David A. Burdock, Sr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Elk Garden, WV 1/18/07 * 4 ☐ Donation 5 ☐ Other (Specify) I.O.O.F. Cemetery 21. Signature of Ineral Service Licenses 22. Name and Address of Facility David A. Burdock Funeral Home 710 Church St., Kitzmiller, MD 21538 wodoo 23a. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) congestire week Due to (or,as a conse cordiovoscular evosaleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ilur c 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No d to be tes 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 page this certificate or Attending Physician: funeral director After s after death.

Physician

/Medical

Examiner

Director

Funera

2

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show with injury or other traumatic avent, the Madical Exercitins the notified at other.

Physician /Medical

Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

in by 1

To the Hospitel o within 24 hours aff To the Funeral Di filled

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier

10025

State Registrar

31. Date filed (Month, 6



30. Name and address of person who completed cause of death (Item 23a) (Typg, Print) Box 247. Accident

State of Maryland / Department of Health and Mental Hygiene UU / Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2007 Rose T. Bounds М 5 2100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Nicomioo TENINSULA REGIONAL Medical Salishum Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🖾 F 216-10-8439 Director 90 Oct. 10, 1916 0klahoma Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Delaware Sussex Delmar Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 35054 Columbia Road 19940 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 222 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: à 3XXWidowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6 Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othen any injury or other traumatic event potes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Costa Marie Greco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 35054 Columbia Road Delmar, DE 19940 Nancy Evans 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-19-2007 Hebron, Maryland 4 Donation 5 Stother (Specify) Entombment Springhill Memory Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street Thuch 19940 Delmar, DE 23a. Part1. Enter the cisease, or com. In that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TICTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) The law requires that the death certificate be executed physicien and s the burial-transit MONORY Due to (or as a consequence of) Physician/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No fo the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М i Director: / 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours eftar of To the Funerel Direct completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) weener D006399 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, MD 21801 Anufana 100 E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 7 2007 Registrar

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January PATRICIA Ε. CULMER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE S DOCTOR'S HOSPITAL LANHAM If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 106-24-7085 76 30 1930 NEW YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD PRINCE GEORGE'S BOWIE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16010 EXCALIBUR ROAD D-222 20716 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status AFRICAN AMERICAN 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 ▼ No 1 ☐ Yes 2 ☑ No Specify. 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th SECETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **EDWARD JENKINS** RUBY HARRIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17203 LONGLEAF DRIVE BOWIE, MARYLAND BRENDA LEE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/13/2007 LANDOVER, MARYLAND HARMONY CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperar Solvice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLISM Due to (or as a consequence of): CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) HYPERTENSION Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 XER/Outpatient 3 □ DOA

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> once.

filed within 72 hours after

Pages 1 and 2 should be

permit.

physician and s the burial-trans as attending nse for ed by the a detached f signed k d be deta page 2 should certificate funeral dir this

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Certification:

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

1 XNatural

that the death certificate be executed After Hospital or Attending thin 24 hours after ueau...

the Funeral Director: Af

Division or Vital Records, P.O. Box 68760,

Medical completely Registrar

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

29c. License number 0042684

28c. Injury at Work?

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAY H. ZWALLY M.D. 575 MAIN STREET SUITE 351 LAUREL, MARYLAND

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, E

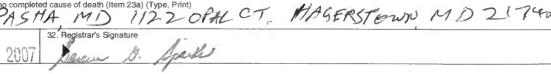


28a. Date of Injury (Month, Day Year)

		1 - For State Registrar	State of Maryla		artment of H rtificate of L	Death	Reg. I	2007	02245		
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last Aberta 4a. Facility Name (If not institution, give	D.		Larr 4b. City, Town, or	Location of Death	January	Day Year 10 2007 4c. County of Dea	3. Time of Death 9: 22 PM		
Funeral Director	eı	The Johns Hop 5. Social Security Number 6. Se 291–34–7658	Kins Hospi	a last birthday) Yrs.	b il	If Under 24 Hrs.	Date of Birth (Mohth, Day, Yea December 8,	9. Bin	thplace (State or Foreign spirity) Shington, D.C.		
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urs a	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 XNo	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify: Bla	e, etc.		
within 72 hours lene. then "natural", the Way cal Exe	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occupa hind of work done of DO NOT use retired Inemployed	ation furing most of working)	16b.	Kind of Business	/Industry		
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Physicia this cert	To B	examiner?	Hospital: Inpatient 2	ER/Outpatie		4 U Nursing Home	5 ☐ Residence		cify)		
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	2	29b. Signature and title of certifier	rie Plice	MA.	29c. License RES	number -000 treet B		NUARY	h, Day, Year)		
Sta	te	30. Name and address of person who come to the state of t		North	Wolfe 9	treet, B	altimore	MA	21287		

(19/13+1

State Registrar 31. Date filed (Month, Day, Year)



		For State		ryland / E	Department of F Certificate of	Health and N	lental Hyg	iene	e.
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/Med Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County of	Death cundel
Funeral Director		5. Social Security Number 6. S 216-16-4042	ex 7. Age	82	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 14,	1924 9	Birthplace (State or Foreign Country Maryland
e Maryland ta-f show tified at	ctor	10a. State 10b. County MD Anne Arus	ndel	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 No
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any injury or other tra once.		21. Signature of Funeral Service	ICA IT SHE		I	2. Name and A			•	ome, P.		Ridgel		
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Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Jack L. Cederloff /Medical Januarv 10. 2007 5:15 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Northhampton Manor Frederick er 1 Year | If Under Frederick 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F Months Yrs 61 Director 562-60-9998 1945California September 15, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Maryland Frederick Walkersville Director 1 □Yes 🔏 😡 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 8510 Adventure Court 21793 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 1 No white ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering other Injury or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Jack B. Cederloff Shirley Meacham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Cederloff wife 8510 Adventure Court, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial 1-13-2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee lue 1621 Opossumtown Pike, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responded, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** oel /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner as the burial-transit and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 attending physician the death certificate be Physician/Medical use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 1 No Division or Vital 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Legical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of ce 29c. License number

3

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who

31. Date filed (Month, Day, Year)

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JAN

MD

32. Regig

Sajjad

Toll House Avenue, Frederick, Maryland

pleted cause of death (Item 23a) (Type, Print)

801

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16, 2007 Crowe January 2:55 P M Ross 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dennett Road Manor Nursing Home 0akland Garrett 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 85 218-16-3642 July 25, 1921 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 0akland Garrett 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21550 USA 1581 Mansfield Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jonas Crowe Mary Martha Beeghley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Connie L. Crowe/ Daughter 1581 Mansfield Road, Oakland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Eglon Cemetery 1/20/07 Eglon, West Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic of ee 22. Name and Address of Facility 32 S. Second St. scall Stewart Funeral Home Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

Physician /Medical Examiner

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/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat; or items 23s or 28e-1 show any injury or other traumatic event, its Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

death with the Maryland

Examine Physician/Medical by Completed Be Certification: To

The law requires that the death certificate be executed use as the burial-tran signed by the attending physician and d be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, certificate has To the Hospital or Attending Physician: funeral within 24 hours after death. To the Funerel Director: A

that initiated events resulting in death) Last	c Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy ar (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underly	ing cause given in Part I.		
25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	26. Place of Dea	th (Check only one)	6 □Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28d. Describe how in 28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exam	vicien: To the best of my knowledge, death occuriner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, ation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signal and title of certifier	Kum 10	29c. License number	29d. C	Date signed (Month, Day, Year)

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Medical

Registrar

DHMH 17 Rev 1/2001

ed (Month, Day, Year)

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ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

12650 1/16/2007 highway oakland ud 21550

			1 - For State Registrar	State of M	aryland		rtment of F		Mental Hyg	iene g. No.) /	02251
	Physici										Yeer 007	3. Time of Death 9:05 A M
}	/Medic Examin									4c. County	of Death	
46	Oakland Nursing and Rehab Center							1and		Ga	rrett	
10 A	Funeral		5. Social Security Number 6. S 233-54-6912	ex	e (In yrs. Ia 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year)	Cour	otace (State or Foreign ntry)
	Director		Usual Residence of Decedent		04	110.			Aug. 6,	1924	West	Virginia
	yland		10a. State 10b. County		10c. City	, Town or Loc	ation				1	Od. Inside City Limits
	Mar Mar	to	MD Garre	tt		0	akland					1 XYes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		16	g. Citizen of	What Cou	ntry?
	23a	ai	1047 East High St	•				21550			SA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any figury or other traumatic event, Ite Madical Examinar most be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 2 ↑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ck, White,	can Indian, etc. Thite
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O. Box	The law requires that the death certi tie has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)				te of delive onth	ery Day Year
۵.	that the ed by detac	Ph.	Part II. Other significant conditions of	ontributing to death b	ut not resu	lting in the un	derlying cause giv	en in Part I.	23e. Did tob	acco use cont	tribute to the	he cause of death?
Sp.	uires sign	d by							1 □ Ye	s 2 No	3 Prob	pably 4 Unknown
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ta	ician: Th certilicate rector, pag	o l	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes 2 ath (Check only one	**	1 🗌 Yes	2 L No
<u> </u>	ysici is cer direci	OB	examiner? 1 ☐ Yes 2 [X]No	Hospital:	ent 2 🗆 E	ER/Outpatient	3□ DOA Oth	05	lome 5 ☐ Reside		er (Specif	iv)
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<u>ö</u>	uttendin death. ctor: Af / the fur	atic	1 XNatural 5 Pending 2 Accident Investigation		, ,	,,		Yes 2 □ No				
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Furneral Director: After this certificate in completely filled in by the funeral director, page	edical C	29a. Certifier 1 X Certifying Ph	ysicien: To the best liner. On the basis of and manner sta	i examinati	vledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	a, and due to the ca arred at the time, da	use(s) and ma te and place,	anner as s and due to	tated. or the cause(s)
	Fo the within Fo the somple	Me	29b. Signature and title of certifier		-		29c. Licens	e number	29	d. Date signe	d (Month _y	Day, Year)
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•			30. Name and address of person who	co peted cause of d	leath (Ite/A	23а) (Туре, Р	Print)	Λ	N 6	1/2	0-	16
			P Daniel V	Mer J	26	The	olt 1	PAR 1	DICO	NOW	ull	MA
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 7	32. Registr.	ar's Signati	ure A	Carl o				211	(391)

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State of Maryland / Department of Health and Mental Hygiene

	- 1	1. For State Certificate of Death Registrar	-	eg. No. 20	07 0225
Physicia	an/	Decedent's Name (First, Middle,Last)	Date of Dea Month	th Day Year	3 Time of Death
∕ledical Exami ∽	ner	Thelma Robinson Cornish 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month January 1	1, 2007 4c. County of I	2230 hrs
		Peninsula Regional Medical Center Salisbury		Wicomico	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Bir		9. Birthplace (State or
Director	- 1	213-16-8102	Oct. 2	22, 1925	Country) Maryland
	ŀ	Usual Residence of Decedent			
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5-06 led wi Hygier other	ট	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, I	Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	8	Levi Robinson Merelia	10 1 1		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	- 1	19a Informant's Name/Relationship (Type, Print) Monroe E. Cornish/son 19b Mailing Address (Street and Number or R 12725 Radburn Place, Fo			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - C	
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: St. James F.M. Cemet. 01/2	20/2007	Quantic	o, Maryland
altin mit Poartme	1	4 Donation 5 Other Specify: St. James F.M. Gemet. 01/2 21 Symature of Funeral Service Licenses 22. Name and Address of Facility 121			
	0. 9	Foretta & Jolley JOLLEY MEMORIAL	CHAPEI		21801
Physician /Medical		23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arr	est, shock, or heart	Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)			Death
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	ner	if any, leading to immediate Due to (or as a consequence of):			
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hed hed	Phys	1 Yes 2 V No 9 Unknown 9 Unknown	220 Did t	haces use contab.	ute to the cause of death?
P.O. es that th igned by	ē	Part II. Other significant conditions—contributing to death but not resulting in the underlying cause given in Part I Bronchopneumonia; breast carcinoma; dementia			Probably 4 V Unknown
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COF Flaw r Phas b e 2 sh	d H			rmed? dea	or to completion of cause of ath?
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Di To the Hospital within 24 hours at To the Funeral I	Medical	check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at			
To To con	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
11.		O.C.M.E.		January 12,	2007
- Mar		30. Name and address of person who completed cause of death (Item 23a)			-
<u> </u>		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
S Regis	tate trar				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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alti	permit. Page Department of Important: If eny Injury or once.	1	21. Signature of Funeral Service Licens		rie	lson (–2007 ∟ unds Fui		nsburg, Home	, MD
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760,	Physician /Medical Examiner be executed by sicion and physicion and physicion and street by the private by the	cai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.						or respiratory ar	•		Approximate Interval Between Onset and Death Year I		
687	ficate g phys	-		1									144	
Vital Records, P.O. Box 68	The law requires that the death certifical te has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 □	Ectopic pre Other (spe						Date of delive Month	ry Day Year
ω, G	w requires that been signed to should be det	y P	Part II. Other significant conditions co.	ntributing to death bu	ut not resu	lting in the un	derlying ca	ause giver	n in Part I.		23e. Did to	bacco use co	ontribute to th	e cause of death?
ğ	equire en sig	ted	17 zerdens	100							1 1	es 2□ No	3 🗆 Proba	ably 4 Unknown
al Reco		Completed									24a. Whas a autop perfor 1 ☐ Yes	sy	b. Were autop prior to con death? 1 Yes	osy findings available inpletion of cause of
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ō	Attending Physician: r death. sctor: After this certifice by the funeral director, I	ت. ع	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	y :	R/Outpatient 28b. Time of		Bc. Injury Work	4 Nur		ne 5 Resid)
ion	ath. rr: After re funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	м		P es 2□N	10				
Division of	or Attence efter death Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	iry - At hor :. (Specify)	me, farm, stre	et, factory,	office		2	28f. Location (S City or Tow	treet and Nui	mber or Rural	Route Number,
	ospital hours at uneral D ly filled i		20a Carifica (D. Carifalia Div	1										
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edicai	29a. Certifier (Check only one) 1 Certifying Physical (Check only one)	sician: To the best oner: On the basis of and manner sta	examination	riedge, death on and/or inve	occurred a estigation,	it the time in my opi	e, date and nion, deat	l place, a h occurre	and due to the c ed at the time, o	ause(s) and late and place	manner as sta e, and due to	ated. the cause(s)
	To the Hospital within 24 hours To the Funeral completely filled	Me	29b. Signature and title of certifier	3			29c.	License	number		2	9d. Date sign	ned (Month, L	Day, Year)
	an,		Palon 13-		~ ~		14	00 3	507	y 3		1/1	5-/2	on 7
1	702		30. Name and address of person who co	mpleted cause of de	eath (Item		rint)					1	1	,
			Robert Brown of 31. Date filed (Month, Day, Year)		205	- Per	محلمه	سعد	- 00	S	مراء ور	vry	mb	21801
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1 -Day 2007 Deville Jr. -8016:11 Charles Т. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Clinton Prince Georges Southern Maryland Hospital Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) (In yrs. last birthday 5. Social Security Number Months Days Hours M 2□F 2/18/1951 Washington DC 55 217-60-6005 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 No Maryland Prince George 10e. Street and Number Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code USA 20773 7606 Deville Ct Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2½ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia Charles T. Deville Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Whist Place, Capital Heights MD 20743 Brenda T. Deville/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/17/07 Clinton, Maryland 4 Donation 5 Other (Specify) Resurrection 21. Signatu e of Luneral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA Aquasco, Maryland V My 191 23a. Part 1. Enter the Issease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Funer Due to (or as consequence of): whan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of):

Physician /Medical **Examiner**

permit, Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other that any Injury or other traumatic event, the once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Funeral

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Completed

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with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner

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Certification:

Medical

attending physician and for use as the burial-tran After this s after dea.

ral Director: After

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

F FEMALE: 23b. Was decedent pr in the past 12 mc 1 Yes 2 N 9 Unknown	egnant onths?	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o 9 □ Unknown	al death 3 □Ectopi						ate of delivery onth Day	Year
art II. Other significa	nt conditions co	ontributing to death but not res	sulting in the underlyin	g caus	e given in Part I.		23e. Did tobacco		tribute to the cau	
				_			24a. Was an autopsy performed? 1 Yes 2 N		Were autopsy fil prior to completi death?	ion of cause of
25. Was case referred	to medical				26. Place of Dea	ath (C	Check only one)			
examiner? 1 Yes 2 No		Hospital: 1 ☐ Inpatient 2X	ER/Outpatient 3	DOA	Other: 4 Nursing H	lome	5 Residence	6 □Ot	her (Specify)	
27. Manner of Death 1 X Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	Injury at Work? 1 ☐ Yes 2 ☐ No	280	d. Describe how inj	ury occu	rred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, street, fac ify)	tory, o	ffice	28f	f. Location (Street a City or Town, Sta	ind Num te)	ber or Rural Rou	ite Number,
29a. Certifier 1 (Check only 2 one) 2	Certifying Phy	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death occur nation and/or investige	red at ition, ir	the time, date and place my opinion, death occ	e, an urred	d due to the cause(I at the time, date a	s) and m nd place	nanner as stated , and due to the	cause(s)

29c. License number

DOOH1580

,Maryland 20735

29d. Date signed (Month, Day, Year)

1-09-2007

filled in by

within 24 hours at To the Funeral C

Scott Kelso MD 31. Date filed (Month, Day, Year) State JAN 1 2 200

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts RD 32. Segistrar's Signature

Clinton

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:59 AM Diags 07 07 101a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis, Maryland Anne Avunde Arundel Medical Center Anne | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | New Year | Ne 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2**%**□ F 80 Yrs. 1926 Maryland Director 212-26-8537 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County 1X Yes 2 No Maryland Anne Arundel Annapolis Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 B Boxwood Rd. Apt 205 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Crownsville College (1-4or 5+) Elementary/Secondary (0-12) Secretary Hospital Center 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Sims Margaret Stepney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 4 0 1 19a. Informant's Name/Relationship (Type. Print) Veda Dorsey(Daughter) 66 College Creek Terrace Annapolis, Md. 20b. Place of Disposition (Name of competes to graph per other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memoriãl Park 1-12-07 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wind Redese of Eacil Sons Mortuary, P.A. Teese MOOY83 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1☐ Yes 2 🗷 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has rector, page 2 25. Was case referred to medical director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: .
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

MD, Anne Arundel Medical Center, Annapolis, MD 21401 1 1 2007 31. Date filed (Month

D0062296

01,07,07

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 03M NNUQUISE /Medical 4a. Facility Name (If not institution, give street and PANINSULA REGIONAL MEDI 4c. County of Death 4b. City, Town, or Location of Death Examiner Vicamica 314130419 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex Social Security Number Age (In yrs, last birthday Sex / 1 ☐ M 2 🔀 F **Funeral** Days Months WEST VIRGINIA Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 XYes 2 □ No Funeral Director WICOMICO SALISBURI 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 2180 26720 PEMBERTON DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER CUNED HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM HURST ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALISBURY, MD 21801 Date | 20c. Location - City or Town, State 26720 PEMBERTON MICHAEL DUNN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1-19-2007 BIVALVE, MD 21814 BIVALVE CEMETERY 4 Donation 5 Dother (Specify) Name and Address of Facility ESSICK FUNERA 21. Signature of Funeral Service Licensee LHOME PO BOX 61 22. Name and Adult STANERAL MUNESSICK FUNERAL MUNESSICK FUNERAL MUNERAL 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumana **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9☐Unknown 9 ☐ Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No cate has by page 2 s After this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 📉 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Hospital 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1577410

4800

State Registrar

DHMH 17 Rev 1/2001

N 17 2007 June 15 April

32. Registrar's Signature

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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E.C

Eng

31. Date filed (Month, Day, Year)

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

amend line 18 per fun delease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco health dept 1/19/07 dlw State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:30P.M. 5 2007 amunu Lena Farrugio /Medical County of Deal Gity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Burnie BUMC Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 167-16-9980 Usual Residence of Decedent PA 86 Apr 28, 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. ?? Is marked other then "naturel", or Items 23s or 28s-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo MD Anne Arundel Annapolis Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21401 429 Dewey Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married land 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other treumatic event SDR. Zappacosto Concettina (unknown) Panfilo DiCredico 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> Joyce Catignani (daughter)</u> 2164 Branchwood Ct Gambrills, MD 21054 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Feb 06, 2007 Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. 12 Ridgely Ave Annapolis MD 21401 enter the mode of dying, such as cardiac of respiratory afrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cone Physician /Medical Due to (or as a consequence of) Examiner when Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Certification: To Be Completed by Physician/Medical for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 perform 1 ☐ Yes 2 □ No 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) the Kun 9447 (1) 30) Hospital Dawe, G 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

B

07-00515 Linda Geary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

		1- For State Control of Certificate of Registrar Certificate of	Health and Ment Death		000	1 2557
Physic Medical Exar	cian nine	1. Decedent's Name (First, Middle,Last)		Reg. 2. Date of Death	-	3. Time of Death
/ = = = = = = = = = = = = = = = = = = =		10 Feeling S. Geary		January 19,		0544 hrs
		02.11a(Cmmm, 11.11	o. City, Town, or Location of Elkton	Death	4c. County of Death	
Funera		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under	24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birt	thnlane (State or
Directo	r	172-42-4002 1 M 2KF 54 Yrs.	Months Days Hours	Min.	Foreig 21,1952 Co.	n
n y		Usual Residence of Decedent 10a State 10b, County 110c City Town out to see 1	<u>-</u>	1 1 1 1 2	21,195 2	untry) PA
bi how a		MD Control of Location		_		10d Inside City Limits
daryland 28a-f show any l at once.	Director	TID CeC11 E1kton	n 10f. Zip Code			1 X Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at one.	غُ ا		21921	10g.	Citizen of What Coun	try?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified an one-	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	Decedent of Hispanic Origin	? (Specify Yes or No-	U.S.A.	and a Division
er deat , or ite		1 Never Married 2 Married Armed Forces? If Yes 1 Yes 2 No	, specify Cuban, Mexican, P	uerto Rican, etc.)	White, etc.	an Indian, Black,
ırs aftı ural"	ھِ	3 Vvidowed 4 Divorced If Yes, Give Year or Dates:	es 2 X No specify:		Specify: Whi	te
C1 2	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's during most	Usual Occupation (Give kin of working life, DO NOT us	id of work done 16 retired)	b. Kind of Business/In	dustry
036 vithin ene ene rr than	100	12 Barte		540	Restaura	n+
215-0036 be filed within ntal Hygiene rked other tha ent, the Medic	ြိ		18.Mother's I	Name (First, Middle, Maid		
1D 21215-0036 2 should be filed within 7 1 and Mental Hygiene 27 is marked tother than matic event, the Medical	To Be	10 10	Unkn	own		
at is	-	Donald Consulta	ddress (Street and Numbe	r or Rural Route Number	City or Town, State,	Zip Code)
ore, ME es l and 2 s of Health at If item 27 her traums		20a. Method of Disposition 20b. Place of Disposition	n (Name of cemetery		c Location - City or T	
Baltimore, bermit. Pages I ar Department of Hee Important: If ites		Removal from State crematory or other	place) _ Ja	nuarv 2ศ.		
Baltimo permit. Page Department of Important:		21. Service Licensee 22. Nam	e and Address of Facility		West Ches	ster, PA
		I And	rew G. Gee	Funeral 1	Home	
Physician /Medical		23a. Part I. If the disease, or complications that caused the death. Do not entire failure. List only one cause on each line.	note of dying sugarity card	c or respireta ARS	hock, MDrt 21	Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death) Methadone intoxication Due to (or as a consequence of):				Between Onset and Death
and the second		Sequentially list conditions, bb.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause				
T	xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed an and al - transit		d				
	//Medical	X UNPENDED AMENDED #23a,27,28a-f perME 9865, 3	/16/07 TT			
	_	23b. Was decedent pregnant in the		2	3d Date of delivery	
Box 68 e death certi the attending ed for use as	sicia	Pregnant at time of death	eath 3Ectopic pre (Specify)	gnancy	Month Day	Year
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certifi Funeral Director: After this certificate has been signed by the attending lely filled in by the funeral director page 2 should be detached for use as it.	Physicia	Ouknown				
s, P.O.	É	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		use contribute to the	
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed				No 3 Probabl	The second secon
e law e has b	d d u			24a. Was an autopsy	prior to com	sy findings available pletion of cause of
tal Records cian: The law requi certificate has been ector. page 2 should		25 Was case referred to medical		performed?	death?	2 No
Vita Vysicia his cer	e Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26 Place of Death (Che			
ing Ph After t	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?	sing Home 5 Resid	ence 6 Other: Sc	ene
ttend death ctor:	Certification:	1 Natural 2 Accident 5 Pending Investigation Fnd 1/19/2007 Fnd 5:15 am	. [7] [7]	unk	ury occurred	1
Division spital or Attentours after death neural Director:	ĘĘ.	3 Suicide 6 X Could not be 28e Place of Injury - At home, farm, street, fac	tory, office building, etc.	28f. Location (Street a	and Number or Rural F	Route Number City
ospita hours uneral		4 Homicide determined (Specify) found at home		193 Hollings	orth Manor E	
41 - 41 0	19 1	check only critifing i hysician. To the best of my knowledge death occurred a	the time, date and place, a	and the second		
Fe the within To the comple	Me	one) 2 Medical Examiner:On the basis of examination and/or investigation, in and manner stated 29b. Signature and title of certifier				i i
		Pat : Anom = Pann	29c. License number O.C.M.E.		Date signed (Month, I	Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)		Jan	uary 19, 2007	
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111	Penn Street, Baltimo	ore, MD 21201		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Negisti	eu	JAN 2 9 2007 Januar Dr. 1900				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

	1 - State Registrar			ertificate of	Death	R	eg. Ne.	7 02261		
ian	Decedent's Name (First, Middle, L EUGENE		ARSHMAN			2. Date of Dea Month January		3. Time of Death 8:14 a. M		
cal ner	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Dea	ath	4c. County o	f Death		
	Frederick Memor	ial Hospita	1	Frede			Fre	derick		
	214-28-5959	Sex 7. Age 1 M 2 F	74 Yrs	Months Davs			, 1932	9. Birthplace (State or Foreig Country) Maryland		
}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limit		
ō	Maryland Freder	ick	Myers	villo				1 ☐ Yes 2X N		
irec	10e. Street and Number		119 01 0	10f. Zip Code		1	0g. Citizen of Wi	hat Country?		
aiD	3702B Brethren (Church Road		2177	3		USA			
by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	io	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	oan, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Black	- American Indian, , White, etc. White		
Completed	15. Decedent's (Specify only highest g	Education	16a. D	ecedent's Usual Occu ive kind of work done ie. DO NOT use retire	pation during most of w	rorking	16b. Kind of Bus	siness/Industry		
ldu	Elementary/Secondary (0-12)	College (1-4or 5	+)	od Clerk	9d)		Cunon M	a w1+ a +		
e Co	17. Father's Name (First, Middle, Las	st)	FO	ou Clerk	18. Mother's N	ame (First, Middle, I	Super M Maiden Sumame			
To Be	Marshall Harold	Harshman				n Marie Sm				
	19a. Informant's Name/Relationship Joyce M. Harshm			ailing Address <i>(Str</i> ee				itate, Zip Code) le, MD 21773		
	20a. Method of Disposition		20b. Place of D	sposition (Name of				City or Town, State		
	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemetery,	crematory or other pla t's Luther		18, 2007		ille, Marylan		
	21. Signature of Fulleral Service Lic	A /	1	22. Name and Addr	ess of Facility	504	Main St	reet		
	Jag Life	ekell		Ricketts 1	Funeral !			MD 21773		
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ty one cause on each lin	the death. Do not	enter the mode of dy	ing, such as cardi	ac or respiratory arr	est,	Approximate Interval Between		
	Immediate Cause (Final disease or condition	· Gastraint	entral	termon has	-			Onset and Death		
	resulting in death)	a.	a consequence of))			190011111111111111111111111111111111111		
ē	Sequentially list conditions,	b. Due to for as	a consequence of).					-		
nine	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events	Due 10 (01 as 2	consequence on							
dicai Examin	Due to (or as a consequence of):									
Med	IF FEMALE:					Sir				
Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	÷y		23d. Date Mont	of delivery h Day Year		
by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e underlying cause g	ven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?		
edt	Anticongelant	THERAPY				1 □ Ye	es 2 No 3	Probably 4 Unknow		
Completed	Disseles Mall	utis)	-			24a. Was a autops		ere autopsy findings available for to completion of cause of		
0	Congestive	HERET FAI	une			perform	næd? de	ath? □Yes 2□No		
ø.	25. Was case referred to medical examiner	Hamilal.				eath (Check only on	(e)			
ш	1 ☐ Yes 2 No	Hospital: 1 Inpatie	-	IIIBIII 3 DOA		Home 5 Reside				
To B	07 Manney of Death	28a. Date of Injur	y 28b. Tim Year) Inju	ry Wo	ork?]Yes 2∐No	28d. Describe ho	w injury occurred			
P	27. Manner of Death 1 Natural 5 Pending	(Month, Day			,		reat and Number			
P		ion be an Bless of lair	iry - At home, farm c. (Specify)	, street, factory, office		28f. Location (St City or Town		r or Rural Route Number,		
Certification; To	1 Natural 5 Pending investigate 3 Suicide 4 Homicide 6 Could not determine	28e. Place of Injubuilding, etc	of my knowledge, of examination and/o	eath occurred at the t	ime, date and pla	City or Town	n, State) ause(s) and man	ner as stated.		
edical Certification; To	1	be 28e. Place of Injubuilding, etc	of my knowledge, of examination and/o	eath occurred at the trinvestigation, in my	ime, date and pla	City or Town	n, State) ause(s) and mana ate and place, an	ner as stated.		
2	Sultural Sultural	28e. Place of Injubuilding, etc	of my knowledge, of examination and/o	eath occurred at the tri investigation, in my	ime, date and pla opinion, death oc se number	City or Town	n, State) ause(s) and mana ate and place, an	ner as stated. nd due to the cause(s)		
edical Certification; To	Sultural Sultural	28e. Place of Injubuilding, etc. Physician: To the best of aminer: On the basis of amount of the state of th	of my knowledge, of examination and/of ted.	eath occurred at the tri rinvestigation, in my 29c. Licen	ime, date and pla opinion, death oc	City or Town	n, State) ause(s) and mana ate and place, an	ner as stated. nd due to the cause(s)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death William Haynes **Physician** Thomas 2000 Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Months Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Hours Days Director 216-40-3998 May 6, 1940 66 Michigan Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland | Prince George's Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 154 Old Enterprise Road 20774 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? or iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced "nature!" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Decupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na any injury or other traumatic event. The Maule 2006. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Frank Haynes Lillian Mae Schaller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Esther Haynes 7929 Mandan Road #302, Greenbelt MD 20770 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 21. Signature of Funeral Service Licensee Chesapeake Crematory 1/17/2007 Beltsville, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. P rt1. Enter the dis se, or shock, or heart laiking Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition Physician KSRHTHMIA resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attending Physicien: The law requires that the death certificete be executed use as the burial-transit and Due to (or as a consequence of) Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be BIABETES MECUTUS 1 Yes 2 No 3 Probably 4 Donknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 1 Yes 2 7 No 25. Was case relerred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Inpatient 2 FER/Outpatient 3□ DDA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number Sholm MD054679 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The Arean. Shopping 575 Main Street, Surte 351, Lowel, MD, 20707 JR Hrora Shohhi
31. Date filed (Month, Day, Year) State JAN 1 6 2007 Registrar

I

Examiner or Attending Physician: The law requires that the death certificate be executed burial-tra Division or Vital Records, P.O. within 24 hours after death To the Funeral Director: completely filled in by the

Physician /Medical

Physician

/Medical

Funeral Director

Be Completed by

မ

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Saltimore, Maryland 21215-0036

	Nancy Streeter -	vaugnter	Hack כס	berry Circi	le She	pherdsto	wn, West	· Virginia			
	20a. Method of Disposition		20b. Place of Disposition cemetery, cremato	(Name of	(Name of Date 20c. Location - City or Town, State						
	1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specification 5		1		lan 17	2007 5m	i+hahuma	Mamuland			
	21. Ignature of Funeral Savor Licer	·	Smithsburg				IIInsburg				
	21. grissfer Fuller	isee		Osborned AdmeradinyHome, P.A. 21795 425 S. Conococheague St. Williamsport, Maryland							
	DOM! V		425	S. Conococh	reague	St. Will	iamsport	, Maryland			
	23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do not enter the	e mode of dying, such a	as cardiac or re	espiratory arrest,		Approximate Interval Between			
	Immediate Cause (Final disease or condition resulting in death)	a. Athero	scleratio	Heart Dis	ease			Onset and Death			
		-	consequence of):								
_	Sequentially list conditions,	b. Prabe	consequence of:		vears						
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		-								
E	that initiated events	C									
Ä	resulting in death) Last	Due to (or as a	consequence of):								
70		d									
퓿		u	·								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown			23d. Date of de Month	livery Day Year						
Ph	Part II Other elemificant conditions		-								
þ	Part II. Other significant conditions of	ontributing to death but	t not resulting in the under	ying cause given in Part	i i.	23e. Did tobacco	o use contribute to	e contribute to the cause of death?			
g	Hypertension					1 ☐ Yes	2 □ No 3 □ P				
et	Prostate Car	Cet			Ì	24a. Was an	Was an 24h Ware outoney findings evallable				
E	310310010	Seat Company				autopsy performed?	prior to death?	utopsy findings available completion of cause of			
ပိ		,		11+-9,00-		1 Yes 2 □	√o 1 ☐ Yes	2 □ No			
Be	25. Was case referred to medical examiner?			26. Plac	ce of Death (C	heck only one)					
ပ္	1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatient 3	□ DOA Other: 4□ N	lursing Home	5 Residence	6 ∏Other (Spe	cify)			
ü	27. Manner of Death	28a. Date of Injury (Month, Day	/ 28b. Time of	28c. Injury at		. Describe how in					
엹	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury	Work? 1	∃No						
ica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of injur	y - At home, farm, street, f	actory office	28f	Location (Ctroot	and Number of D				
Medical Certification: To	4 ☐ Homicide determined	building, etc.	(Specify)	43.0.77 0.1100	201.	City or Town, Sta	and Number of Al	ural Route Number,			
Ö	29a. Certifier 1 Certifying Ph		form large last a state of		1						
ica	(Crieck only 2 Medical Exam	niner: On the basis of a	urred at the time, date a gation, in my opinion, de	and place, and eath occurred a	due to the cause at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)				
ed	G/IC)	and manner stat	ed.								
2	29b. Signature and title of certifier			29c. License number			ate signed (Mont				
	30. Name and address of person who of Cynthia Kutther - S	ttree-Sa	nds mo	D47451		Ja	nuary 1	7,2007			
	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type Print	3 04 15	24 11			1 02/16			
	Grothia Kuttner-	Sands No	14214 Paradi	se Church K	ca, Hag	perstown	Maryla	and 21172			

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

SH 10+1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 🖯 🗋 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Columbus Haywood Harris AM January 12, 2007 5:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Fort Washington Hospital Fort Washington Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year)
Nov. 12, 1916 North Carolina Birthplace (State or Foreign
Country) **Funeral** Months Days 90 Yrs. Director 242-12-0431 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "neturel", or items 23e or 28a-1 show eny finjury or other treumatic event, "the Medical Event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X☐ No Completed by Funeral Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1026 Floyd Avenue 20602 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Excavation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Ancel Harris Adaline Finney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lura B. Harris - Wife 1026 Floyd Avenue, Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns 1-17-2007 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility M00053 3035 Old Washington Road Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myer carcher
Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed the attending physicien and the attending the stransition of the stran Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 an/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performe 1□ Yes 2□ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 124 hours 2 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medicai Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and tiple of fertifier 29c. License number 29d. Date signed (Month, Day, Year) Mma MD D0055120 January 12 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) my 1323 Southern avinue SE Suck STD Washington DC 20032 Cechanol falme 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2007 JAN 1 6 Registrar

07-00613									
Vicky	Ε.	Howard							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	To Be		Mailing Address (Street and Number or Rural Route N 215 Home Place, La Plat						
	두 명품 표정		20a. Method of Disposition 20b. Place of	215 Home Place, La Plat f Disposition (Name of cemetery. Date	20. Location - City or Town, State					
	MOF Pages ent of int: If		1 Burial 2 X Cremation 3 Removal from State Brins:	Field-Echols 1/28/07						
	Baltimopermit Pag Department Important: injury or or		21. Signature of Funeral Service Licensee M00945 23a. Part I. Enter the disease, or complications that caused the death. Do no	² AREHARTSECHOLS FUNER 211 St. Mary's Ave. I	RAL HOME,P.A. La Plata.MD 20646					
	Physician /Medical	u 1	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic card.)		arrest, shock, or heart Approximate Interval Between Onset and Death					
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	Divis ne Hospital or At n 24 hours after d ne Funeral Direct oletely filled in by	cal Certification:	4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, dea							
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certifica	29a, Certifier							
	Divis To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	nvestigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)					
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	29c. License number O.C.M.E.	te and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Lois Evelyn Hinks 9, 2007 January 11:30 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 ☐ M 2 🗹 F Hours 043-07-0908 91 Yrs Director Feb 8, 1915 Connecticut Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Westminster Carroll 1 XYes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Timber Ridge Drive apt 313 21157 USA death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. \$ Specify: 3 ₩idowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Claims Adjuster 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence M. Barrett Edna E. Ferris ್ತಿ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryll A. Lay, daughter 2006 Don Avenue, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State South Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2007 Carroll Crematory Signature of Funeral Service Licensee M01191 Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) uncreanie Cancer montas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3X Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 X No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: P 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Mother (Specify) NOSP(C 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 10 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 6701 J. Chrus BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Janauray 13, 2007 9:10P M Arthur L. Hargett 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Frederick Vindobona Nursing Home Braddock Heights If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 31,1911 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours TXXM 2 F 214-10-1410 95 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Fiyes 2 INo Frederick Maryland Frederick 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 7405 Hilltop Drive 21702 **USA** . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Manager Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer T., Hargett Minnie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrick Hargett/Son 7813 Grandview Place, Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/16/2007 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Frederick, MD 22. Name and Address of Facility Stauffer FuneralHome, PA 21. Signature of Funeral Servi 1621 Opossumtown Pike, Frederick, MD 21702 23a 7ft). Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONGESTIVE NEMPT MLURE disease or condition resulting in death) Due to (or as a consequence of): YETHPS ORGHARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTUSE LUNG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown PHEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending Physician:

within 2

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

ortant: If Item 27 is marked other than "natural" or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment.

within 72 hours after

Baltimore, Maryland 21215-0036

bunial-transit and physician the attending pl the ò pe peen has page certificate director, this

Examine Physician/Medical Ď Completed Be ၉ filled in by the funeral Certification: within 24 hours after death. To the Funeral Director: After

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Yes 2 No

6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier MEN

1)16675

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar

Medical

31. Date filed (Month, Day, Year) 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 13 2007 Donald Otto Hankla 7:41 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ XM 2 □ F Months Days Hours 579-36-8279 75 March 28, 1931 Washington D.C Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15031 North Franklinville Road 21788 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 TXYes 2 □ No If Yes, Give 1950-58 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Sewing Machine Sales Elementary/Secondary (0-12) College (1-4or 5+) Owner-Operator and Repairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Hankla Mabel Frederica Statler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Hankla, Sr. - Son 15031 North Franklinville Road, Thurmont, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematorium 1/16/07 Alexandria, Virginia 4 □ Denation 5 □ Other (Specify) 21. Signature of Ameral Service Licensi Molesworth-Williams P.A., Funeral Home overi 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death avdiony opat immediate Cause (Final disease or condition resulting in death) proving Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes → I No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed and burial-tran Division or Vital Records, P.O. Box 68760. physician the as attending Jse for ed by the signed I page 2 certificate has Physician; Hospital or Attending

funeral director. After this death. n 24 hours after death letely filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

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r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death

Il Hygiene.

Depertment of Health and Mental Hygien Important: If Item 27 Is marked other than any Injury or other traumant.

Physician

/Medical Examiner

Examiner

Physician/Medical

Completed by

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Certification: To

Baltimore, Maryland 21215-0036

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Registrar

31. Date filed (Month, Day, Year)

JAN 16 2007

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 50060417

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

1-15-07

Pohnson Br. Frederick MD 2170

MB 65 C Thomas

32. Registrar's Signature

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	amin		4a. Facility Name (If not institution, g					Location of Death		4c. Count	ty of Death	
			THE JOHNS HOPE		e (In yrs. la		GALTIM If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9 Right	lace (State or Foreign
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death	r mus	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerl	pecify Yes or No)- 14. Ra	ace - Americ	
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and 2 st ealth and n 27 Is n	er traun		19a. Informant's Name/Relationship Benjamin Hotchk			3630	ng Address (Street Glenoble	Court,				*
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Dallillo permit. Pages Department of Important: If It	any inju once.		21. Signature of Funeral Service Lic	censee dul			2. Name and Address Boal Fune	ss of Facility		out Mo	l	a 21562
			23a. Part1. Enter the dise e, or co shock, or heart failure. List on	omplications that caused	d the death.	Do not ent	111 Churc ter the mode of dyir	ng, such as cardiac	or respiratory a	ort, Ma rrest,	Гутап	Approximate Interval Between
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X OX sertifica ding pl	se as t	Med	IF FEMALE:	23c. If yes, outcome	of pregnan	CV						
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VII.al slclan: 1 certifical	irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	1 T E	D/Outpotion	nt 3□ DOA Oth	er:				
g Phy er this	eral d	ت: <u>1</u>	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o	11 3 DOX	4 □ Nursing ⊓	ome 5 Res	how injury occu		<i>y)</i>
VISION Attending r death. ector: After	ne fun	atio	1 Natural 5 ☐ Pending investigat	tion	ly rear)	Injury		Yes 2 □ No				
DIVIS al or Atte after de	d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	280. Flace of IIII	jury - At horr tc. (Specify)	ne, farm, str	eet, factory, office			Street and Nun wn, State)	nber or Rura	d Route Number,
e Hospit 24 hours e Funera	letely fille	Medical (Physician: To the best xaminer: On the basis of and manner st	of examination							
To the within	lmoo	Me	29b. Signature and title of certifier				29c. Licens	e number	·	29d. Date sign		Day, Year) 2007
			30. Name and address of person who were plus plus plus plus plus plus plus plus				Print) -FE S	T BAL	TIMORE	, MD	21	289
Re	Sta gistr		31. Date filed (Month, Day, Year) JAN 1 8	32 Pariete	rar's Signatu		Cooth 1					
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			1 - For State Registrar	State of Maryland / [Departme <i>Certifica</i>				•	giene	0.7	02271
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath	9 1	3. Time of Death
	Physici		Nadia	Said Hani					Month Januar	Day 14, 2	Year 007	6:15 A ^M
	/Medid Examir		4a. Facility Name (If not institution,		4b. City	, Town, or	Location of	of Death	Januar		4c. County of Death	
1	LAGIIII		FutureCare - Ir	vington	Da	144					timor	·e
	Funeral			6. Sex 7. Age (In yrs. last bir	thday) If Unde	ltimo	If Under		8. Date of Bin	th		place (State or Foreign
П	Director		218-82-3227	1□ M 2□ X F 64	Yrs. Months	Days	Hours	Min.	(Month, Da	y, Year) .7 , 1942		estine
	P .		Usual Residence of Decedent							., .,.,		
	arylan show	_	10a. State 10b. County	10c. City, Tow	n or Location							10d. Inside City Limits
	Ba-1:	cto	Maryland Fred	erick Adams	stown							1 ☐ Yes 2 📉 No
	or 24	Dire	10e. Street and Number		10f. Z	p Code				10g. Citizen of V	What Cou	ntry?
	23a	rai	3154 Flinthill	Road	2	1710				U.S.A.	•	
	tems tems	ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece If Yes, spe	edent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		e - Americk, White,	can Indian,
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examinat must be molified at	by Funeral Director	1 Never Married 2 Marrie	If Yes, Give	1 🗆 Yes	2 V No	Specify:				. Whi	
21215-0036	hour tural	b D	3 X Widowed 4 □ Divorced	Year or Dates:								
5	n 72	Completed	15. Decedent's (Specify only highest		Decedent's Usi (Give kind of w life. DO NOT	ork done a	luring most	t of worki	ng	16b. Kind of Bu	ısiness/ln	dustry
12	withil ene. than	μğ	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemak		,			0 11		
9	Hygi Hygi ther ant, I		17. Father's Name (First, Middle, L	ast)	Homemak	.e.	18 Mothe	r's Name	(First Middle	Own Ho		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-1 show item 27 is marked other than "natural", or Items Example or Items for notified at	o Be	Wadie Jeries Kh						Wadie		.6)	
<u>-</u>	mari mati	2	19a. Informant's Name/Relationshi		Mailing Address	s (Stroot s				ar, City or Town,	State Zie	Code
Z	and 2 salth ar		Nader Hani / Son									
ē,	Health tem 27 tother tra		20a. Method of Disposition	20b. Place of	Disposition (Na	me of			dams cow	n, Mary		
lo I	ages int of t: If i		1 ☑ Burial 2 ☐ Cremation 3	3 ⊟Hemovai from State	ry, crematory`or	,	´ 1	. /1-	107		•	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Funeral Service Li	TO SECULIAR	uls Cem			1/17	/0/	Germant	own,	Maryland
Ba	permit. Departr Importa any inju		Milathis	Jun Marco	Moles	worth	1-Wil	liams	s P.A.,	Funera	1 Hon	ne
			23a. Part1. Enter the disease, or o	omplications that caused the death. Do	26401	Kidg de of dvind	ge Roa	ad,	Damascu r respiratory ar	s, Mary	Land	20872 Approximate
			shock, or heart failure. List o Immediate Cause (Final	nry one cause on each line.						1031,		Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. PERSISTENT		CIA	100	- 8	TASE			
	Examiner		1	Due to (or as a consequence of the CENE BRO V)	of): An could Am	_1	No.	100	20			
		e	Sequentially list conditions,	b. Luc to (or as a consequence	of).	, ,	//					
	uted Insit	m H	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hopenson	EN SISV	V						
Ć,	exec n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	of):						-	
8760,	cate be executed physician and the burial-transIt	dicai		DIABETE	5 /	reu	1 14	5				
.89	ificati g phy as the	edic		U								
Вох	eath certifi attending I for use as	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy						23d. Dat	e of delive	erv
m .	death certifi e attending I id for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic p 5 □ Other (s	regnancy pecify)				Moi		Day Year
		hys	9 Unknown	9□ Unknown								
٣.	The law requires that the ste has been signed by th page 2 should be detache	by P	Part II. Other significant condition	s contributing to death but not resulting in	the underlying	cause give	n in Part I.		23e. Did to	bacco use contr	ibute to th	ne cause of death?
Ď	w require been sig should b								1 🗆 Y	′es 2□No	3 🗌 Prob	ably 4 Donknown
Records,	law requas been 2 should	Completed							24a. Was		Vere auto	psy findings available
ä	The late ha	E o							autop	med?	leath?	inpletion of cause of
		0	25. Was case referred to medical		_		26 Place	of Death	1 ☐ Yes (Check only o	100	Yes	2 No
>	ysic s ce direc	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 D	OA Othe	_ /			lence 6 Othe	ar (Snecifi	z)
		T :u	27. Manner of Death			28c. Injury Work				ow injury occurr		,
0	Attending ir death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investiga	ition	М		es 2 🗆 1	No				
Division	r Atte	Certification;	3 Suicide 6 Could no 4 Homicide determin		rm, street, factor	y, office		2	28f. Location (S City or Tow	Street and Number	ar or Aura	l Route Number,
	tal or	Cer		ballaling, old. (Spoolity)				- 1	Only of Ton	n, Siale)		
	ne Hospital or Attendii n 24 hours after death. ne Funeral Director: Al pletely filled in by the fu		29a. Certifier 1 Certifying (Check only 2 Medical E	Physicien: To the best of my knowledge xaminer: On the basis of examination and	, death occurred	at the tim	e, date and	d place, a	nd due to the	cause(s) and ma	nner as st	ated.
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	0/10)	and manner stated.				III OCCUITE	⊸ at trie time, (Jate and place, a	ına aue ta	ine cause(s)
	To To	Σ	29b. Signature and title of certifier		1	c. License		40	:	29d. Date signed	(Month,	mile
	,			ATTENDING		100.	569	78		JAN	11	2004
8				ho completed cause of death (Item 23a) (em		2	. —		- 3
			JANES Thus	32. Sistrar's Signature	27 PC	Acc	· fr	uit-	34 /3	ntimoni	710	2/2/
	Sta		31. Date filed (Month, Day, Year)	32. Sistrar's Signature	had	,						
	Registr	ar	JAN + 0	2001	Marie							

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	State of Mary	•	artment of F		Mental Hygie	/ 11 1	02273
	-	2	Decedent's Name (First, Middle, La	ist)				2. Date of Death		3. Time of Death
	Physici /Medio		Gregory	Dean		Isdell		January 1	Day Year 11,2007	12:55 A M
	Examin		4a. Facility Name (If not institution, gir				r Location of Death		4c. County of Death	
意。		. 44	6901 Zion Church	Road		Salis	bury		Wicomic	0
1/4 170	Funeral			Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birti Co	nplace (State or Foreign untry)
	Director		216-/0-/185	46	6 Yrs.			4-22-196	0 Mar	yland
	and *		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Marylan f show	ō	MD 114 4		0 - 1 - 1					1 ☐ Yes 2X No
	28e	Director	MD Wicomio	20	Salisbury	10f. Zip Code		10g.	. Citizen of What Co	untry?
	3a or		6901 Zion Church	Road		2180	4		USA	•
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Si	pecify Yes or No-	14. Race - Ame	
21215-0036	o 72 hours after death with the Maryland "natural", or Itema 23a or 28e-f show cilical Examinational be notified at	5	1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	o Hican, etc.)	Specify: Wh	
9	2 ho	Completed	15. Decedent's E			dent's Usual Occup			b. Kind of Business/l	ndustry
215	⊆ 1 3	a pie	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	kind of work done DO NOT use retired	during most of wor.	NIII 9		
2	filed with Hygiene. other ther	Son	12		Owner	/Operato	r	U	tility	
nd	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Las	1)			18. Mother's Nan	ne (First, Middle, Mai	iden Sumame)	
Χ		၉	James Edward Isde				Betty Ma	1 2		
Maryland	and reum	1 3	19a. Informant's Name/Relationship		19b. Mailir	ig Address (Street	and Number or Ru	ral Route Number, C.	ity or Town, State, Z	ip Code)
di.	s 1 and 2 should I Health and Mer Item 27 is marke other treumatic		Sharonlee Isdell 20a. Method of Disposition	V1	6901 20b. Place of Dispo	Zion Chi	urch Road	Date 200	ry, MD 21. Location - City or	
Baltimore,	if it it		1 M Burial 2 ☐ Cremation 3 [Removal from State	cemetery, crei	natory or other plac		200	s. Location - Oily or	own, state
∄	it. Partment		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	<u> </u>	1d School	L Baptist . Name and Addre			rsonsbur	, MD
Ba	permit. Pages 1 Depertment of H Important: If Ite any Injury or ot 20058.		May 16	Black.			D	ounds Fund Salisbury) <i>(</i>
			23a. Pagri. Enter the disease, or con shock, or heart failure. List only	notifications that caused the						Approximate
	Dhamisisa		shock, or heart failure. List only Immediate Cause (Final							Interval Between Onset and Death
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	be executed sicien and burial-transit	Examine	that initiated events	c						
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9	entific fing p	Me	IF FEMALE:	O2a If use outcome of a			***	557 98-2-		
Box	eath certific attending p	hysician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy	1		23d. Date of deli	very Day Year
o.	at the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	a or death 2F	Other (specify) _				
0	that the ed by detail	0	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
of Vital Records,	The law requires that the te has been signed by the age 2 should be detache	d by						1 🗆 Yes	2 3 Pro	obably 4 Unknown
00	w requir been si should I	ompieted						24a. Was an	24b Were au	topsy findings available
Re	The lar	mc						autopsy performed	d? prior to death?	ompletion of cause of
a		ပိ	25. Was case referred to medical	10			26 Place of Dea	th Check only one	No 1 Yes	2□ No
>	Physician: this certific al director,	0 B	examiner?	Hospital:	2 ER/Outpatier	t 3 DOA Oth		ome 5 Residence	e 6 Other (Spec	orful
		-	27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe how		
io	Attending r death.	atio	1 Natural 5 Pending 2 Accident investigation		ea <i>r)</i> Injury		Yes 2 □ No			
Division	er de recto by tr	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		At home, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru	ral Route Number,
	tal or A	Cer		- Januaria, 5.6. (5						
	To the Hospital or within 24 hours afte to To the Funerel Dire completely filled in t	Medical	29a. Certifier Check only one) Check only one)	hysician: To the best of m miner: On the basis of exa and manner stated	amination and/or in	n occurred at the tire vestigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licens		29d.	Date signed (Month	n, Day, Year)
	1 Pro		· GV	//		03	0690	3	-a. 11,	2007
5	0			mpleted cause of death	(Item 23a) (Type,				CHARLES AND A STREET	4
-)			ertin, MiD	, 145	E. Corro	11 51,	, 5,1.5	bury	nD.
9	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature					
4.2	Registi	ar	JAN 12	UUI BACKE	H. A					

		•	For State Registrar	State	of Maryla		artment of H			giene.	7 02275
2.	Physicia /Medic		1. Decedent's Name (First, Middle, La		erly Ani	n Jones			2. Date of Dea Month January	Day Ye	3. Time of Death 7 10:40 P M
	Examin	er	4a. Facility Name (If not institution, given 729 Spruce Stree	t			Hage	Location of Death		4c. County of Wash	
'n	Funeral Director			Sex 1 □ M 2 🂢 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day July 7	y, Year)	Birthplece (State or Foreign Country) orth Carolina
	Maryland	tor	10a. State 10b. County NC Richmo	ond	10c. C	City, Town or Lo					10d. Inside City Limits 1 □XYes 2 □ No
	th with the 23s or 28s	Funeral Director	10e. Sireet and Number 2416 Eagle Dr.				10f. Zip Code	906		10g. Citizen of Wha U	al Country?
2	permit. Pages 1 and 2 should be lied within 72 hours atter death with the Maryland Department of Heath and Menial Hygiene. Department of Heath 21 e marked other than "natural", or itema 23a or 28a-f show eny Injury or other traumatic event, I're Madical Examinat mast be notified at appear.		11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	2□No ive 61		Was Decedent of Hi If Yes, specify Cubal 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc. White
20-013	hin 72 hou e. nn "natura Medical E.	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed		(Give	denl's Usual Occupa kind of work done d DO NOT use retired,	luring most of work	ing	16b. Kind of Busin	
7 7 7	be filed wit tal Hygiene d other the	Be Corr	12 17. Father's Name (First, Middle, Las	t)			Customer			Maiden Sumame)	ical
wal yia	d 2 should h and Men 7 le marke traumatic	7	Chivous B. D. 19a. Informant's Name/Relationship	(Type, Print)	- 1		ng Address (Street a	and Number or Run		er, City or Town, Sta	ate, Zip Code)
<u>ה</u>	ages 1 and ages 1 and of Healt it it it it it it it it it it it it it		Tracy R. Block (I 20a. Method of Disposition 1 Burial 2 Kremation 3 [4 Donation 5 Other (Speci	☐Removal from	20b.	Place of Dispo cemetery, crea	esition (Name of matory or other place	Jan.	Date 15,	20c. Location - Cit	
Dall	permit. P Depertme Importan eny Injur ance.		21. Signature of Funeral Service Lice		s Ma	22	g Cremato 2. Name and Addres 7.L. Davis	s of Facility	12	2525 Brad	burg,Md. bury Ave. ,Md. 21783
	hysician		23a Part: Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	polications that one cause on	caused the deleach line.	ath. Do not en	er the mode of dying	1 1			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	b	(or as a conse		V	(0010		
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse						
00/00	ificate be executed g physicien and as the burial-transit	dical	(d							
.O. DOX	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of preg birth 2 ☐ Fe gnant at time of nown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
COLUS, T	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to	death bul not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to		ite to the cause of death? Probably 4 Unknown
מארו	sicien: The law re certificete has bei irector, page 2 sho	Completed								rmed / dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
ח אומו	To the Hospital or Attending Physicien: The within 24 Hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death			□ ER/Outpatie		4 Nursing no	ome 5□Resid	dence 6 ⊟Other (equal ton
NSIGN	Attending r death. octor: After by the funer	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	on	of Injury nth, Day Year) ce of Injury - At		Work	res 2 □ No	28f. Location (S	now injury occurred	or Rural Route Number.
Ś	ospital or hours afte unerat Dire iy filled in t		29a. Certifier 1 Certifying P	hysician: To th	ne best of my ki	nowledge, deat	h occurred at the tim	e, date and place,	City or Tow	cause(s) and manne	er as stated.
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and ma	nner stated.	nation and/or in	29c. License			date and place, and 29d. Date signed (A	due to the cause(s) Month, Day, Year)
, j	11-1		30. Name and address of person who	completed cau	0 1	em 23a) (Type,	Print)	1 30 C	> 11	Jewien D.	15,2007
UN A	1+/ Sta Registr	-	31. Date filed (Month, Day, Year)	2007	Registrar's Sig	nature A. A	ale	Thue	16	for the	in mil

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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #8, perFH, G864, 2/20/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Timothy Douglas Jackson 2007 7:40 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll 209 Troon Circle Mt. Airy 8. Date of Birth Serffonth, Day, Year) Adg. 16, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days **№** M 2□ F Yrs Maryland 1959 215-78-9780 47 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director Mt. Airy Marvland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 209 Troon Circle 21771 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 N Married White Baltimore, Maryland 21215-0036 1 ☐ Yes Ž**OX**No ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than Welding Equiptment Sales injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Menta Dorothy Tyler Egbert H. Jackson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 209 Troon Circle, Mt. Airy, MD 21771 Health tem 27 I Jackson / Wife Esme' 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-15-2007 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Stauffer Crematory 21. Signatural Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 8 East Ridgeville Blvd., Mt. Airy, MD 21771 Pair1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mitastatic Maddee Physician disease or condition resulting in death) 2° metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner he law requires that the death certificate be executed burial-tran that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Tes 2 should Completed een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No pe ge certificate 1∐ Yes Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ို 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Dav. Year)

MD

15 althous

MD 2120

January 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. GREENE 22 USS+

31. Date filed (Month, Day, Year)

32. Registrar's Signature

07-00373 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Shane Derek Jones 1- For State Certificate of Death Registrar Date of Death Time of Dear Decedent's Name (First, Middle,Last) Physician/ Month Day January 13, 2007 0652 hrs Medical Examiner Shane Derek Jones c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Cumberland Memorial Hospital 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** oreign Hours Days Min Director 19,1984 Maryland 1 **X** M 214-06-8659 2 F 22 Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No 23a or 28a-f show notified at once. Grantsville MD Garrett with the Man land Director 10f. Zip Code 10g Citizen of What Country 10e. Street and Number 21536 USA 401 Bill Beitzel Rd. Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. 11. Marital Status þ Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death v 1 X Never Married 2 Married must Yes 2 X No o. White Yes 2 X No specify Divorced If Yes, Give Year Specify hours after ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene Important: If item 27 is marked other than "t injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 10 Carpenter Building Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beverly K. Beitzel Gregory A. Jones Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly K. Jones/Mother 401 Bill Beitzel Rd., Grantsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 2007 Hagerstown, MD Hagerstown Crematorium Jan. 16, Donation 5 Other Specify 22. Name and Address of Facility Newman Funeral Homes, P.A. Signature of Funeral Service Licenses umali P.O. Box 275, Grantsville, MD 21536 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure List only one cause on each line /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - trai Physician/Medical UNPENDED AMENDED The law requires that the death certificate be P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of performed? death? 2 No. ✓ Yes 2 No 1 🗸 Yes After this certificate 26 Place of Death (Check only one To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital 1 Other₄ Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 Residence 6 1 🗸 Yes 28a. Date of Injury FOUND: 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury 28c Injury at Work Certification: Subject shot self FOUND: Natural Yes 2 V No Pendina - death Director: the 0543 hrs Jan 13, 2007 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 401 Bill Beitzel Road, Grantsville, MD 24 hours a Funeral I (Specify) Mobile Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29c License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie MD O.C.M.E. January 14, 2007 1 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

State

Registra

31. Date filed (Month

Year)

2007

aistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day January 10, 2007 Louis Kirkland Robert 4:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Year)
Sept. 27, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min Months Hours Director 1924 Washington, DC 577-18-1305 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits al Hygiene. I other then "natural", or items 23a or 28e-f show vent. The Madical Examinat must be notitied at 28e-f show Director 1 ☐ Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 N. Leisure World Blvd., 20906 death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. be filed within 72 hours after 1√2 Yes 2 □ No
If Yes, Give 1943-46
Year or Dates: 1 Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) District of Columbia 10 Surveying Engineer traumatic sysnt, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ဥ William Louis Kirkland Doris Augusta Dammeyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20906 19a. Informant's Name/Relationship (Type, Print) f Health Itsm 27 other tra Maureen O'Brien Kirkland/ Wife 3210 N. Leisure World Blvd., #708, Silver Spring, 20b. Place of Disposition (Name of Date 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its sny injury or ot once. cemetery, crematory or other place) 1 StBurial 2 Cremation 3 Pemoval from State January Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, 21. Signature of Funeral Service License Francis of Tivins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due 1 The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 → 6 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 9099 Division of Vital 2[] N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Limitient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending efter death.
I Director: Afl
d in by the fur 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funaral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ince Phillip Br. Olney, MD orenzo 1810

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) JAN 12

2007

ORIGINAL

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Balkissa Monique Kassambara 2112PM 05-2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CV 635 Sprine MD HOBILS Iver Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 25 XF Months Days Hours 2 0 None Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No Director Maryland Prince George's Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4201 Kaywood Drive #9 20712 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 ▼ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Hamady Seyni Kassambara Sonia Omojowo Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 Kaywood Drive #9, Mount Rainier, MD 20712 Sonia Kassambara / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 1/15/2007 Brentwood, MD 21. Signature of Fun val Service Dicensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1 Enter the dis ase, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Immediated use (Final disease or condition **Physician** 95022 resulting in death) /Medical Due to (or as a conse uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1□ Yes 2 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ral Birector: After this cral Director: After this cral in by the funeral director. Hospital: 1 Yes 2 No 1 / Inpatient ပ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Tyes 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 1 200 7 1000 D34292

State Registrar 31. Date filed (Month, Day, Year)

JAN 12 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

SIVEN Spring, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 Jan. 9:40 AM Catherine Jacqueline Kennon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1232 Ritchie Highway Anne Arundel Arnold If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 350-14-1867 Oct 20 1922 84 Illinois Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event, the Medical Examiner must he natural and one. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21401 USA 2570 Riva Road, Unit 15C Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify. Completed by Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Ritthaler Raymond O'Connell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2570 Riva Road, Unit 15-C, Annapolis, MD 21401 John Bendell (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 1-9-2007 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any solid to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 ☐ Unknown ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Qunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 **2** No 1□ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. After this after death To the Hospital or Atte within 24 hours after de:

To the Funeral Directo completely filled in by the

1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 🗌 Yes 2 ☐ Accident 6 Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

AT 6HWAY ANAPILLS

Other: 4 Nursing Home 5 Residence 6 Hether (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

son Mo completed cause of death (Item 28a) (Type, Print) M M 44)

31. Date filed (Month, Day, Year)

JAN 0 9 2007 egistrar's Signature

State

Registrar

Amended Item 19a per F.D. 01/17/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 20:34 FOOC ERMIT, KEYSER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DIVERSITY OF MARYLAND MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo 6/3/1915 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days **Funeral** Days 218-10-8723 1 X M 2 □ F 91 Maryland Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director MD Baltimore Upperco 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 15303 Old Hanover Road 21155 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturanting or other traumatic averages." 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Shoe Maker Shoe Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leida Hamrick Howard Keyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) La Informatis Name/Belationshie (Type Print) - Wife 15303 Old Hanover Road, Upperco, MD 21155 Erma Margaret Keyser 20b. Place of Disposition (Name of Krider S 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 1/15/2007 Cemetery 22. Name and Address of Facility Eline Functal Home, 934 South 21. Signature of Funeral Service Licensee Main Street Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SYNDROM & **Physician** HERNIAMINOZH /Medical Due to (or as a consequence of): Examiner HERMORHAGE INTRACEDEBRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by tha e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ vis certificate has been signi director, page 2 should be 1 Yes 2 No 3 Probably 4 Nonknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 2 Accident eftar death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number WIL 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEZLER WY CELTY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Α. WILLIAM LYNCH SR 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland MEMORIAL HOSPITL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 11, 1934 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1√ M 2 □ F Director 215-26-9584 72 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10a. State 10d. Inside City Limits Cumberland MD Allegany 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 318 Davidson Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1951-53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No Baltimore, Maryland 21215-0036 Specify: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver lumber company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Collins Lynch Henry Anthony Lynch ပ 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 318 Davidson Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Naomi Lynch wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Sunset Memorial Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/25/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name Scarbell Furteral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** 1dan /Medical Due to or as a consequence of): Examiner Ovonary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by t id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1. Natural 5 Pending investigation ours after death.
nerel Director: A 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funerel I 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number ne and address of person who complete 120

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O 2007 Month Catherine Elizabeth Litton) An 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12/10/1934 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 214-34-9993 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18906 Waldron Place 21742 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Insley Dudley, Sr. Catherine Elizabeth Margaret Bingley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Pastena/Daughter 21 Winged Foot Drive, Medford, NY 11763 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 01/16/2007 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Aste Zueeks Due to (or as a consequence Perforted Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): IE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Physician/Medical Examiner

Department o Important: If I any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

show

"natural", or Items 23a or 28a-f shov dical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene.
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Baltimore, Maryland 21215-0036

Director

Funeral

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Certification:

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

JH-10

State Registrar

31. Date filed (Month, Day, Year) JAN

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIGGIE MO

6 Could not be determined

ILL'S O 32. Registrar's Signature

and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

03876

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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	/Medical		resulting in death)	Due to (or a	s a consec	quence of):	1	- 0	0	112		al I	
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DHMH 17 Rev 1/2001

per fh 1/12/07 State of State and State and health dlw State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** January 2 2007 4:00 p ^M Dorothy Lamb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2570 Riva Road, #13C Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Director 219-12-3328 82 Nov 7 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2570 Riva Road, 13C 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify. White Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
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Department of H
Important: If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 1-6-2007 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gatas Hardesty Funeral Home, P.A 12 Ridgley Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 □ Yes 2 🖬 🕇 🛈 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of iours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1033069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Detense Highway Stelog Bevinstein 31. Date filed (Month, Day, Year) State JAN 0 9 2007 Registrar

amend #19aPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7

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		•	1 - For State Registrar	otato or mar	Ce	ertificate of		Re	ng. No.	77 02200		
			1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month	h	3. Time of Death		
	Physici /Medic		Robert D	uane I	Lataille			January	7, 200	07 4:40 p. м		
	Examin	_	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death			of Death				
			Anne Arundel Medi			Annapo1		T =		Arundel		
d	Funeral Director		5. Social Security Number 6. Se 001-34-4805	7. Age (/ X 2 F 60	n yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 7,	1946	9. Birthplace (Stete or Foreign Country) New Hampshire		
	and		10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits		
	Maryi	ŏ	NH Rockingha	ım T	Portsmout	h				1 ☐ Yes 2 🙀 No		
	28a	Director	10e. Street and Number	1	Olesmoue	10f. Zip Code		10	Og. Citizen of W	/hat Country?		
	h with	<u></u>	445 Ocean Road #2			03801			Jnited S	States		
	deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H	fispanic Origin? (Sp	ecify Yes or No-		- American Indian, c, White, etc.		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Dependents if item 27 is marked other than "natural, or items 23s or 28s-f show supportant: if item 27 is marked other than "natural, or items 23s or 28s-f show supply injury or other traumatic event, the Madical Exerting relation and once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give Year or Dates:	1964- 1967	1 ☐ Yes 2 X No		7 110211, 010.7	Specify:			
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dec	edent's Usual Occup e kind of work done	pation during most of work	una	16b. Kind of Bu	siness/Industry		
2	ithin	npl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		T 	rian Comphania		
21	ygier ygier t,	Co		5+	Pro	ject Mana				tion Systems		
and	d off	Be		's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden								
3	d Mer narke	၉	Romeo Louis Latai 19a. Informant's Name/Relationship (T)		10h Mai	line Address /Ctract		Loretta M		Chata Zin Confe)		
Maryland	d 2 st th and 7 is r traur		Jeffrey M. Latail		4	ling Address (Street Fairfiel			-			
	1 and Healthean 2		20a. Method of Disposition		20b. Place of Disr	osition (Name of		Date 2		City or Town, State		
Baltimore,	ages ent of ht: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 █ Other (Specify)		•	ematory`or other pla rarv. Ceme t	Jane	12,	Manchest			
Ħ	mit. F Sertme Sortar Injur		2 ature of Funeral Service Licens			Name and Address of Facility Advent Fu			· · · · · · · · · · · · · · · · · · ·			
ä	Depermine ony ir		M00982 42 Hudson St., Suite 110 Annapolis, MD 21401									
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
			Immediate Cause (Final disease or condition	PAN	CREAS	A))(Remod	UA		Onset and Death		
		resulting in death) Due to (or as a consequence of):										
н		_	Sequentially list conditions,	b								
	ed ssit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c								
mat initiated events c. Pue to (or as a consequence of):												
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687	ificate p phy: as the	Medical	~	u								
Вох	nding use s		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy				23d. Date of		of delivery		
	that the death cer	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim		☐Ectopic pregnanc ☐ Other (specify) _	у		Mon	th Day Year		
P.0	at the	hy	9 ☐ Unknown									
	igned be de	þ	Part II. Other significant conditions co	ntributing to death but r	not resulting in the	underlying cause giv	en in Part I.			co use contribute to the cause of death?		
ord	w requires to been signer should be	ted				_ .		1 70	Yes 2 No 3 Probably 4 Unknown			
ec	e 2 sl	Completed						24a. Was ar autops	psy prior to completion of cause of			
So to the control of								performed? death? 1 ☐ Yes 2/XNo 1 ☐ Yes 2/XNo				
Ž.	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		ent 3 DOA Ott	or.	th (Check only one				
ō	Phys rah di	2	1 Yes 2 No	1 22 inpatient	2 ER/Outpation	SILL OF DOX	4 🗀 i tursing ric	28d Describe ho				
	ding In. In. After funer	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	rear) Injury	Wo	rk? Yes 2 □No	28d. Describe how injury occurred				
Division	Attending r death. ector: After y the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury		treet, factory, office		28f. Location (Street and Number		or Rural Route Number,		
27. Manper of Death 1									, State)			
	hour uner uner		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of r	ny knowledge, dea	th occurred at the ti	me, date and place,	and due to the ca	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical	one)	and manner stated	1.	Josephion, army C						
	10 Vitt	<	29b. Signature and title of certifier	d 0150	1111	29c. Licens	e number	29	o. Date signed	(Month, Dey, Year)		
			HORAG	March	MI	V	2000		1110	010+		
	291		30. Name and address of person who c	empleted cause of deep	h (Item 23a) (Tyro	Print TAX	DE 1803	MAGO	DARDI	1824021401		
	Sta	to	31. Date filed (Month, Day, Year)	32 Registrar's	Signature			-	3110			
	Registr		IAN 1 1 20		As A	8 - 00 -						

07-00460 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Steven Leatherbury State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day January 16, 2007 **Medical Examiner** 2252 hrs Purnell Leatherbury Stephen 4a Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In vrs. last birthday) **Funeral** 9. Birthouse (State or Foreign Months Days Hours Director Country land 216-56-2290 1 X M 2 55 June 15 195 Usual Residence of Decedent any 10b. County 10c. City. Town or Location 10d Inside City Limits 23a or 28a-f show 1 Yes 2 death with the Maryland Maryland Wicomico Fruitland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 213 Poplar Street 21826 U.S.A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Armed Forces 1 Never Married 2 X Married White etc. Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify. Specify Black 'natural", ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical injury or other traumatic event, the Medical Baltimore, MD 21215-0036 Laborer None 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Leatherbury Sr. Marilyn Moody ဥ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Leatherbury (Mother) 213 Poplar St.Fruitland, Md. 21826 20b. Place of Disposition (Name of cem-crematory or other place) Mem 20a Method of Disposition Date 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify Springhill Garden 1 - 23 - 07Hebron, Md. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Stewart Funeral Home Sladys B. 821 West Rd.Salisbury, Md.21801 Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Intracerebral hemorrhage complicating cocaine use Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause. Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last d sician/Medical physician a X UNPENDED AMENDED, 23a, 27, perME, FH, g865, 3/1/07 TT Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 1 🗸 Yes 25. Was case referred to medical Division of Vital the Hospital or Attending Physiciau: hin 24 hours after death 26.Place of Death (Check only one) Be examiner? Other₄ 1 Inpatient 2 VER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes ဥ 2 No 28a. Date of Injury (Month, Day, Year) Manner of Death 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 5 Pending Yes 2 No hin 24 hours after death the Funeral Director: the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

State Registrar DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

Ana Rubio MD.

(Me)

31. Date filed (MANY Day, Gar 2007

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c License number

O.C.M.E.

29d Date signed (Month, Day, Year)

January 17, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Maryla	nd / Depa		Health a	-		007	02288	
	Decedent's Name (First, Middle, Last)								2. Date of Death		3. Time of Death	
	Physici /Medic Examin	al	Lucy Jane Lambert 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death					Jan Death	12 4c. C	2007 ounty of Death	1:24 a ^M	
	Examin	er	2325 Coon Club	_		Westmi			1	rroll		
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs	last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of B	irth Day, Year)	9. Birth	place (State or Foreign intry) MD	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits	
	death with the Maryland ims 23a or 28a-f show r must be notified at	tor	MD Carr	oll	Westmi	nster				ļ	1 ☐ Yes 2 ☐No	
	or 28	Director	10e. Street and Number		-	10f. Zip Code			10g. Citize	on of What Cou	intry?	
	sath v	rai	2325 Coon Club	Road 12. Was Decedent Ever in U	16 121	21157		in? (Specify Voc or h	USA	. Race - Ameri	ngo Indian	
	should be filed within 72 hours after death with the Marylan of Manded Hygiens and Hygiens then "natural", or flems 23a or 28a-f show marked other then "natural", or flems 23a or 28a-f show matte event, its Madical Examinar main be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		was Decedent of the lift Yes, specify Cub. 1 ☐ Yes 2 ☐ ★10		in? (Specify Yes or N Puerto Rican, etc.)		Bleck, White,		
9	2 hou	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occu	pation	of working	16b. Kind	of Business/Ir		
1215	within 7 ne. hen "n	To Be Completed	(Specify only highest gra	life.	kind of work done during most of working DO NOT use retired)				Union Bridge Clothing Co			
q 5	filed v Hygie Sther t		17. Father's Name (First, Middle, Last)			Presse	18. Mother	's Name (First, Midd			CO	
lan.	Mental Mental arked o		Caleb Wolfe				Fanr	nie Winf:	ield			
Mary			19a. Informant's Name/Relationship (t and Number	or Rural Route Num	ber, City or 1			
e)	is 1 and 2 of Health a litem 27 is other trai		Helen Waddell/c			COON C esition (Name of matory or other pla		d Westmi		tion - City or T		
mor	ages ent of h ht: If ite ry or of		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemovai irom State		natory or other pla eek Cen		/15/2007	8		10	
Baltimore, Maryland 21215-0036	permit. Pages 1 and Depertment of Healinportant: If Item 2 any injury or other once.		21. Signature of Funeral Service Licer		² f	Nantaged Addr	ruffery	al Home	and C	hapel		
P	Physician /Medical Examiner		23a. Part I. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea						Inster	Approximate Interval Between	
			timmediate Cause (Final disease or condition resulting in death) Let only one cause or cardine. Let only one cause or cardine. On Cardinary party Due to (or as a consequence of):							Onset and Death		
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	ocuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
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89	tificate ng phy: as the			0				-				
P.O. Box	The law requires that the death certifica site has been signed by the atlending ph page 2 should be detached for use as th	Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnance Other (specify) _	ey .		23	d. Date of deliv Month	rery Day Year	
œ.	res that I igned by be deta		Part II. Other significant conditions of	ontributing to death but not re	suiting in the u	nderlying cause gr	ven in Part I.	23e. Dio	tobacco use	contribute to t	the cause of death?	
ord	w require been sig should b							1	Yes 2	No 3 ☐ Prol	bably 4 ⊟⊎hknown	
Division of Vital Records,								per	s an opsy formed?	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available ompletion of cause of	
/ita	clan: ertific ector,		25. Was case referred to medical examiner?			1-		of Death (Check onl)	-			
of \	Physicism: The I this certificate har ral director, page	J.	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home							fy)	
0	ding th. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred			
Divisi	f or Attanding after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str lify)	eet, factory, office		28f. Location City or T	(Street and I	Number or Run	al Route Number,	
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	MZ To Withing the same	M	29b. Signature and title of certifier	La MD		29c. Licen	se number \$203	5	Jar	signed (Month,	Day, Year) 12,2007	
	Wood		30. Name and address of person who BINU CHACCO	completed cause of death (Ite	Λ			23 mine f	, P			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign								
	Registr	ar	JAN 1 6	2007 Jan	K	Joen K						

DHMH 17 Rev 1/2001

ORIGINAL

			State of Ma 1- State Registrar Amend #5, perFH, C869, 7/12/	ryland / Depa 07 TT <i>Cei</i>	artment of He rtificate of D			ene 0 0 7	02289
			Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death
	Physici /Medio		John Raymond Lusby, J	r			Jan	13 2007	8:26 a M
}	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of Deat	h
			402 Ringneck Ct.		Reiste			Baltimo	re
	Funeral		J410	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		217-03-3410	90 Yrs.	,-		June 18		MD
	pu s]	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ecation				10d. Inside City Limits
	sho	5							1 Yes 2 XNo
	N 94	Directo	MD Baltimore	Rei	sterstow	n			Tel.
	Aith of a	급	10e. Street and Number		10f. Zip Code			g. Citizen of What Co	ountry?
	e 23	era	402 Ringneck Ct.		211	 		JSA	2
	hours after death with the Maryland ural, or tleme 23a or 28e-f ehow al Examinar must be multiled at	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	1942	Was Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
5	ir, or	by	1 □ Never Married 2 □ Married 1 □ ¥es 2 □ No 1 □ Yes Give 3 □ Widowed 4 □ Divorced Year or Dates:	1945	1 ☐ Yes 2 ☐ X No	Specify:		Specify: W	nite
12-0036	i 72 hours after death with the Marylan "natural", or iteme 23a or 28a-f show issical Examinat in malika malified at	ed	15. Decedent's Education	16a. Decer	dent's Usual Occupati	on	11	6b. Kind of Business/	
5	within 72 ene. than "nat	Completed	(Specify only highest grade completed)	(Give	kind of work done dui DO NOT use retired)	ring most of work	ing		
7	the die	E	Elementary/Secondary (0·12) College (1-4or 5+	1	cery Sup	erinter	dant	Acme	
0	othe othe	BeC	17. Father's Name (First, Middle, Last)	GIO	CELY DUD	8. Mother's Name	(First, Middle, Ma		
ā	ould be Menta Merked Merked	ToB	John R. Lusby, Sr			Rachel	Brvan		
2	Shound N	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and			City or Tawa, State	Tip Code)
2	nd 2 alth a 27 is		John R. Lusby III/son	629	Morelock	School	house F	20	21158
<u>6</u>	s 1 a f Hei item othe	-	20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)		Date 20	Oc. Location - City or	
Baitimor	Pages entol		1 ☐Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	e Park C	1	1/2007	Paltimos	CO M D
E	ortan		21. Signature of Funeral Service Licensee						
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			23a. Part1. Enter the disease, or complications that caused t	he death. Do not ente				The second secon	Approximate
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		9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):	oc vast	May and			2094
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מ	deati e atte	lcia	1 Ves 2 No. 4 Pregnant at ti		Ectopic pregnancy Other (specify)			Month	Day Year
j.	t the by th tache	hys	9 ☐ Unknown 9 ☐ Unknown						
ທົ	uires that the de signed by the a ld be detached f	by P	Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Sora	w requires been sign should be						1 ☐ Yes	2 □ No 3 1 Pr	obably 4 DUnknown
ပ္တ	- 0 m	Completed					24a. Was an	24b. Were au	topsy findings available
Ě	o - 0	E					autopsy	prior to death?	completion of cause of
VITA	ician: Th certificate rector, pag	0	25. Was case referred to medical		2	6 Place of Death	1 ☐ Yes 2	No 1 ☐ Yes	2□ No
-	Physician: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	Other	4 Nursing Ho		ce 6 □Other (Spe	26.1
Ö	g Phys er this eral di	T:	27. Manner of Death 28a. Date of Injury	28b. Time of			28d. Describe how		ny)
0	Attending I ir death. ector: After by the funer	atio	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury		s 2 □No			
DIVISION	ar de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, stre	eet, factory, office		28f. Location (Stre	et and Number or Ru	ral Route Number,
5	s afte	Cert	building, etc.	(Specity)			City or Town,	State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a Certifier 1 Certifying Physician: Title ball (Check only 2 Medical Examiner: On the basis of a	my knowledge, daat	conumed at the time	date and place, t	and due to the cau	se(s) and ir anner as	stated.
	the H hin 24 the Fi nplete	edical	(Check only one) 2 Medical Examiner: On the basis of each one) and manner state	xamination and/or inv	restigation, in my opin	ion, death occurr	ed at the time, date	e and place, and due	to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier		29c. License n			d. Date signed (Monti	**
	WITH		June Muddleta	mD	D25	443		115/2	167
	N 15/1A		30. Name and address of person who completed cause of de-	ath (Item 23a) (Type,	Print)	1 3000	1	1.212	
	10.	,	John W. Middleton mi	D 6 88 1	Print) Poole Ro	e, Wie	the sing	ter mi	21157
	Sta		31. Date filed (Month, Day, Year) 32. Registrar	s Signature	_		THE STATE OF THE S		-
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			For State	State	of Marylan	-		lealth and M		2.0	0.7	02200
			Registrar	(====)		Cer	tificate of L	Jealli	2. Date of Dea	leg. No	UI	J Z Z J U
	Physicia	an	Decedent's Name (First, Middle, There 1						Month	Day	Year	3. Time of Death
	/Medic	al	Frank	Cass		nthicu		Location of Death	January	7	2007 by of Death	9:30 P M
	Examin	er	4a. Facility Name (If not institution, Citizens Nurs	-			Frederi				lerick	
	Funeral Director		5. Social Security Number 220–32–7325	6.Sex 1XIM 2□F	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept.	(, Year)	9. Birthp Coun Mary	lace (State or Foreign try) 1and
			Usual Residence of Decedent						1			
	how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits 1 No No
	Ba-f	5	Maryland Freder	rick	Fr	ederic	k					
	ith th	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of		itry?
	ath w		1900 Rosemon				2170			U.S.A		
36	in 72 hours after death with the Maryland "neturel; or iteme 23e or 28e-f ehow colcal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed F ed 1 ∑ Yes If Yes, G	2 □ No ive	1	Mas Decedent of Hi fYes, specify Cuba I□Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	ВІ	ace - Americ ack, White, ity: Whi	etc.
21215-0036	hour turei	q pe	15. Decedent's	Year or I	Dates: WWI		lent's Usual Occupa	ation		16b. Kind of	Rusiness/Inc	dustor
Ċ	filed within 72 Hygiene. Ither then "net ent, the Madic	Completed	(Specify only highest	grade completed		(Give	kind of work done of NOT use retired	during most of work	ring	Trucki		Justry
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7			17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	e (First, Middle,			11 3
a	D 2 2 0	To Be	John Dutro	w Linth	nicum			Leon	a Davi	ic		
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street	and Number or Rui			n, State, Zip	Code)
	and 2 salth a n 27 is		William H. Ragso	dale – gi	candson	409	Cherrywoo	d Court,	Willia	msburg	. Vir	ginia 2318
Z.	- 포함하		20a. Method of Disposition	2		Place of Dispo	sition (Name of natory or other plac	201	Date	20c. Location	- City or To	wn, State
Ĕ	Pages nent of I ant: if it		1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ∐Hemovai from ecify)	Hy	attsto	wn Cemete	ery 01/	16/2001	Hyatts	town,	Maryland
Baltimore,	permit. Pag Depertment Important: f eny injury o		21. Signature of Fureral Service C	icense il	iems		olesworth	s William ge Road,	s P.A.,	Funera	1 Home	e 20872
			23a, Part1. Enter the disease, or o	complications that	caused the deal					-	y Land	Approximate Interval Between
	Pnysician	(1)	shock, or heart failure. List of Immediate Cause (Final	only one cause on	each inte.	My	Deens	dial	Tank	mae A	1000	Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	o (or as a consec		0 00.0	Cr DO 1	Line	allo	200.	
н	Examiner		Conventially lies conditions	b		U			J			
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to	o (or as a consec	quence of):						
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	,							
60,	cate be executed physicien and the burial-transit	E E	yourning in country case	Due to	o (or as a consec	quence or):						
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	eath certific ettending p I for use as	/Me	IF FEMALE:	23c. If yes, o	utcome of pregn	ancy				23d F	ate of delive	201
Вох	etter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Feta gnant at time of c	al death 3	Ectopic pregnancy Other (specify)				nonth	Day Year
o.	the d	Jysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk								
<u>.</u>	res that the de signed by the e be detached f	by Pi	Part If. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to th	ne cause of death?
ğ	w require been sig shoutd b								101	res 2□No	3 🗌 Prob	pably 4 Onknown
ပ္သ	aw re	Completed							24a. Was	an 245	. Were auto	psy findings available mpletion of cause of
æ	The lav	E							autop perfo 1 Tes	rmed? 2 No	death?	
ta	ician: Th certificete rector, peg	Be	25. Was case referred to medical examiner?	4				26. Place of Dea				
<u>></u>	Physician: this certifice ral director, p	5	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2] ER/Outpatier	nt 3 DOA	er: 4 ursing He	ome 5 Resid	dence 6 🗆 O	ther (Specif	(y)
ב	Attending Physician: Ir death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending		e of Injury onth, Day Year)	28b. Time of Injury	Wor		28d. Describe h	now injury occ	urred	
sio	death.	cati	2 Accident investig 3 Suicide 6 Could n	ation				Yes 2 □ No				
Division of Vital Records,	F 0 F C	Certification:	4 Homicide determi	ned 200. Plat	ding, etc. (Speci	ify)	eet, factory, office		City or Tov		nder or Hura	al Route Number,
	To the Hospitai or Attending I within 24 hours efter death. To the Funerei Director: After completely filled in by the funer	edical C	(Check only 2 Medical	Examiner: On the	basis of examina	owledge, death	h occurred at the tir vestigation, in my o	me, date and place, ppinion, death occur	and due to the	cause(s) and r	manner as s	tated.
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		29c. Licens			29d. Date sign		``
	8 7 % 7		255. Signature and little of capitale	1		110	n	TD 29	1	/	/^	07
. \	M		30. Name and address of person	no completed ca	use of death (Ite	m 23a) (Tvna	Print)	3021		/ -	12-	21701
	H1.		SAJJAO	A212,				enue- Sui	ite 3C,	Freder	ick. M	21701 Maryland
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32.	Pegistrar's Sign	ature			•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIRM#23b, perPHYS. G863, 1/29/07, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 01 11 07 2348 /Medical Virginia Ε. Mi11 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS- Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2□F 4-6-1917 224-32-9485 89 Director VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the Marianian Control of the shown in the shown 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Funeral Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 1/2 Marshall Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Warren Lee Wines Kate Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jo Randall/ daughter 11194 Mt. Zion Church Rd., Brandy Station, VA 22714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middleburg Mem. Cemetery 1/17/2007 Middleburg, VA 22. Name and Address of Facility Scarpelli Funeral Home, PA for 21. Signature of Funeral Service Licensee Royston Funeral Home, Middleburg, VA 20118 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, incl., or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ach line Pumo NI A **Physician** day disease or condition resulting in death) /Medical Accident Examiner 1 monte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform meo? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Director: After Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 126907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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harwaush RD. Cumbercaud, NO 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Lula Moragne Ν. January 18,2007 /Medical 4:50P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton
If Under 1 Year | If Under 2 Prince Georges 8. Date of Birth (Month, Day, Year) 9. Birthplace (5 Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Days 1 M 2 S F Director 250-50-8139 78 July 19,1928 SC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 □ No Directo Md. PG Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural", or items 23a 1606 Birchwood Drive Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ James Wright <u>Fannie B. Baltimore</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Birchwood Drive Oxon Hill, Md. 20745 Department of Health a Important: If Item 27 is any injury or other train once. Evealla Wright/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 1/24/07 Clinton, Md. 22 Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md. 20746 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I hre liate Cause (Final d ease or condition resulting in death) **Physician** ANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 임 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier s of person who completed cause of death (Item 23a) (Type, Print)

State Registrar D LINE CONTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of DeathMonth 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year Physician 08 PT W 2007 Danvary 16 ELIZABETH MIDDLETON DELLA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chererty Cerrae's Hospika trince Colone's enter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number , Funeral Days Hours 1 ☐ M 2 🖸 F 87 MAY 13 1919 MARYLAND 220-34**-**2978 Director Usual Residence of Decedenl 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-1 show the Medical Examiner must be notified at 1X Yes 2 □ No PRINCE GEORGE"S SEAT PLEASANT MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 U.S.A. 614 63 PLACE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ Year or Dates: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 8th MAINTENANCE GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) other traumatic avent, 17. Father's Name (First, Middle, Last) and Mental P 9 FRANK WASHINGTON CLARINE WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14204 OLD STAGE ROAD BOWIE, MARYLAND 20720 Health Item 27 DELLA E. KNOTT/SISTER altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. ö 1/16/2007 LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral ervice Licensee J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscleratic Hypertensive Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Exam Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 No 5 Cher (specify) 4☐Pregnant at time of death P.O. I ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2x No 1 Tyes certificate 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 Tyes 2 No death. Diractor: / 2 Accident investigation 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after 1 To the Funerel Dirac 4 - Homicide pellij 1 Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica completely (Check only one) and manner slated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

JAN 1 6 2007

32. Régistrar's Signature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician TAN 200/ Charles Robert Martin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospital 7. Age (In yrs. last birthday) Washington County Washington County cial Security Number 6. Sex Hagerstown If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 63 19 Director 1943 Maryland July 213-42-1262 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ី No Director Maryland Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 10728 VanLear Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🐧 No If Yes, Give Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Mfg. Radial Drill Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest F. Martin Reba Chaney Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10728 VanLear Dr. Williamsport Maryland Bonnie Martin (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1-15-07 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd, N. Hagerstown Maryland 21742 23a. Part 1. Enter the dise see, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lentoneal Carcinomales disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lance Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perforn 1□ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

VIH-20

30. Name and address of person who completed cause of death them 2 a) (Type, Print)

Espons

Year)

31. Date filed (Month, Day,

30

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0000 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician ELIZABETH 2007 GEORGIA JANUARY 10, 7:00 AM M MORRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WALDORF HEALTHCARE CENTER WALDORF CHARLES 8. Date of Birth (Month, Day, MAY 5, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 □ M 2 🕅 F 1916 004-26-1157 90 MAINE Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 X No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3106 BRAEBURN ROAD 20601 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. and 2 should be filed within 72 hours after (ealth and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No <u>__</u> Specify Specify: 3 Widowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be sand Mental RICHARD COYLE ANNIE KERVIN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) f Health BARBARA A. MORRIS - DAUGHTER 3106 BRAEBURN ROAD, WALDFORD, MARYLAND 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 JANUARY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 X Other (Specify) ENTOMBMENT TRINITY MEMORIAL GDN 15, 2007 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HUNTT FUNERAL HOME या अ 3035 OLD WASHINGTON RD., WALDORF, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MROMBOSIS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tra Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Hospital: 1 ☐ inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Description in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JANUARY 11, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVIN PATEL, MD, 102 PAUL MELLON COURT, WALDORF, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 JAN 12 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4a.perPHYS., C863, 1/29/07, WS
State of Maryland / Department of Health and Mental Hygiene

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-	Examin		4a. Facility Name (If not institution, a	ve street and curr	ber)		4b. City, Town, o	r Location of Death		4c. County		3.50	
			-11-Pennsylvania	Avenue			Walkersv			Frede			
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036	filed within 72 hours after death with the Maryland Hybione. ther than "natural" or Items 23a or 28a-f show int, the Medical Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Da	e ites: 1945	-46	1 ☐ Yes 2 📉 No	Specify:		Specify	Whit	e	
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7	filed v Hygie ther t nt, th	ပိ	17. Father's Name (First, Middle, Las	5+		Journ	alist	18. Mother's Nan	ne (First Middle	News/Me			
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ore	iges 1 s nt of He if item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Demovel from 6		Piace of Disno	osition (Name of matory or other place		Date	20c. Location -			
<u><u>Ĕ</u></u>	Pages ment of I ant: if ite ury or o		Donation 5 Other Spec				t Cemete:			Frederio	ck, Ma	aryla:	nd
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Lic	Basfor	d Fun	eral 1	Home						
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			shock or heart failure. List on	y one cause on ea	ach line.	n. Do not en	ter the mode of dyli	ng, such as cardiac	or respiratory as	rrest,		Approxima Interval Be Onset and	tween Death
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68760,			resulting in death) Last	Due to (or as a conseq	uence of):					ļ		
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f	Med	29b. Signature and title of certifier	and manr	ier stated.		29c. Licens	se number		29d. Date signe	d (Month. I	Day, Year)	
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	10		30. Name and address of person wh	o completed caus	e of death (Iter	n 23a) (Type,	D4186	00	J	lanuary	18, 2	UU/	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0832AM 07 2007 Jan vary /Medical 4b. City, Town, or Location of Death 4c. County of Death ility Name (#.not institution, give street and number) Examiner There ohn If Under 1 Year | If Under 24 Hrs. 8. Date of Sirth
(Month, Day, Year)
Jan 25 19 Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 F 9 214-49-6234 Yrs 1997 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? filed within 72 hours after death with 21144 1864 Hawk Ct. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Black Specify ģ 3 Widowed 4 Divorced Completed the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "many injury or other traumatin many injury or other many or other many or other many or other many or other many or other many or other many or other many or other many or other ma Elementary/Secondary (0-12) College (1-4or 5+) 4th 0 Student Schoo1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eversly Mills Starleen Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eversly Mills(Father) 1864 Hawk Ct. Severn, Md. 21144 20b Place of Disposition (Name of Beneder, Charles) y or other place)
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1 - 15 - 07Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wind Name Red Sees of & acid Sons Mortuary, P.A. Lavry J. Reese MOO 483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days neumonia /Medical Due to (or as a consequence of): Examiner cleroderm Sequentially list conditions, if any, leading to immediate cause. Enta underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.0. the detached 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has page 2: autopsy performed? certificate Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at Work? or Attending Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Street

MD

600 North

Registrar's Signature

30. Name and address of person who completed bause of death (Item 23a) (Type, Print)

Shilkofski

JAN 1 1 2007

29d. Date signed (Month, Day, Year)

January or 2007

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			Frederick Memo	orial Hosp	ital		I	red	erick	ς			Fr	eder:	ick	
100	Funeral Director		5. Social Security Number 544-52-9590	6. Sex 1 □ M 2 √ 1	7. Age (In yrs. 58	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi July 2	irth lay, Yea .6, I	948	9. Birthi Oreg	olace (State ntry) On	or Foreigi
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21215-0036	s within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	Armed For	2 XNo		Was Deced If Yes, spec		lispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)	lo-		ck, White,	can Indian, etc. White	
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Maryland	2 should and Men is marke	은	Eldon 19a. Informant's Name/Relations		Eskew,		ng Address	(Street	Syt		al Route Num	ber, City	Scot		Code)	
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Ball	permit. Par Departmen Important: any injury		21. Signature of Funeral Service	Licensee		2	2. Name an	d Addre	ss of Facil	^{ity} Sta	uffer	Fune	ra1	Home	, PA	
4	40= 60		23a, Parti. Enter the disease, or	eder	ick,	MD :	21702	4-								
			23a. Part . Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	iii. Do not en	n			s cardiac i	or respiratory	arrest,			Approxima Interval Be Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a. Due to	or as a consec	- VV	2 me	NO	m	~	(110)	,				
4	Examiner			Exte	MANUE	Metal	ahro	(a	Neta	Pe	drà lu	ver	Luna			
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	VIII (1100	1	111	,	0.1)	1,		
	be executed cian and ourial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	с												
60,	be exectan sourial-	_ 1	resulting in death) Last	Due to (or as a conseq	quence of):										
687		dice		d					-							
P.O. Box (death ce e attendii d for use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	al death 3[⊒Ectopic pre ⊒ Other (spe		/					ate of deliv	ery Day	Year
	requires that the een signed by th hould be detache		Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the u	nderlying ca	use giv	en in Part	l.	23e. Did	tobacco	use con	tribute to t	he cause of	death?
or Vital Records,	w requires been sign should be	d by									1 🗆	Yes	2 □ No	3 ☐ Prol	oably 4	Unknown
900	Sp	plete									24a. Wa		24b.	Were auto	psy findings	available
Ä	The ate h	Completed									auto peri 124 Yes	opsy formed? 2 □ N	lo l	prior to co death? 1 XYes	mpletion of	cause of
/ita	clan: ertifica ctor,	Be C	25. Was case referred to medical examiner?						26. Place	e of Deat	h (Check only			127103	20,140	
7	Physician: r this certificaral director,	은	1 Yes 2X No			ER/Outpatie			4 🗆 N	ursing Ho	me 5□Res	sidence	6 □Ot	her (Specia	fy)	
OU C	ding I. After funer	ion:	27. Manner of Death 1 ☒ Natural 5 ☐ Pendin	9	th, Day Year)	28b. Time o Injury		Bc. Injur Worl			28d. Describe	how inj	ury occu	rred		
Division	Attending r death. ector: After by the funer	ficat	2 Accident investig	not be	of injury - At he	ome, farm, st	M reet. factory		Yes 2□		28f. Location	(Street s	and Num	her or Rus	al Route Nu	mhor
$\frac{1}{2}$	al or / s after i Dire d in b	Certification:	4 Homicide	buildi	ng, etc. (Specii	fy)	,				City or To	own, Sta	te)	oci oi iidii	ar riodle radi	noei,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certify r	g Physician: To the	best of my kno	owledge, deat	h occurred	at the tir	me, date a	nd place,	and due to the	e cause(s) and m	anner as s	stated.	
	the H iin 24 the Fi	edical	One)	Examiner: On the ba and mann	ner stated.	ation and/or ir				atn occur	red at the time	e, date a	nd place	, and due t	o the cause	(s)
	with To	Σ	29b. Signature and title of contifie	10/7					e number	10	1, -, ,				Day, Year)	
١,	1		· H	VI 2			- 4	0 (00	60	411		1-1	5-	0/	
_	1		30. Name and address of person Ghulam Abbas	400 W.	7th St	reet,	Frede		k, MD	217	01					
3	Sta Registr		31. Date filed (Month, Day, Year) JAN 1	6 2007	gistrar's Signa	A A	berte	,								

				State of Mi	arylaliu / L	Department of Certificate of		-	giene Reg. No.2	0.7	02299
	Physic	ian	Decedent's Name (First, Middle, Las	•				2. Date of Dea		Year	3. Time of Death
1	/Medi		VIRGINIA		MISTER			Januar		OO7	5:27 PM
1	Examir	ner	4e. Fecility Name (If not institution, give				4b. City, Town, or		,		
			McCready Memorial 5. Sociel Security Number 6. Se		e (In yrs. lest bir	thday) If Under 1 Year		field		Somer	
	Funeral Director			M 2⊠F		Yrs. Months Deys			y, Yeer) 1909	9. Binnp Coun Maryl	lace (Stete or Foreign try) and
	yland yland		10e. State 10b. County		10c. City, Town	n or Location				1	0d. Inside City Limits
	a-f s	Ş	Maryland Somer	rset		C	risfield				1 Yes 2 □ No
	章 章 章 章 章 章 章 章 章 章 章 章 章 章 章 章 章 章 章	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhet Coun	itry?
	ath w		6 Second Street				21817			JSA	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Menyland Depertment of Health and Mentel Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show shy injury or other traumatic evant, if a Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Detes:	Ever in U,S. No	13. Was Decedent of If Yes, specify Cult		Specify Yes or No- to Rican, etc.)	- 14. Rac Bled Specify	e - Americ k, White, W	an Indian, etc. hite
'n	72 h	etec	15. Decedent's Edu (Specify only highest gred	ucation de completed)	16e.	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	pation e during most of wa	rkina	16b. Kind of B	siness/Inc	dustry
2	vithin hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NOT use retire	ed)	9			
N	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)			Homema	7	me (First, Middle,		Own H	ome
a	d be sentel	To Be	Archibald White					Northam	Maiden Suman	Θ)	
2	should ind Men i merke umetic	F	19a. Informant's Name/Relationship (T	vpe, Print)	19b.	. Mailing Address (Stree			er City or Town	State Zin	Code)
Ž	and 2 ealth a n 27 is		Raymond Mister (So	on)		3079 Boone					
Š.	of Heritem		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other ple		Date	20c. Location -		
Ĕ	Pages nent of I ant: if ite		1 ABurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			idge Memori		1/17/07	Crisfiel	d. M	arvland
baltimore,	permit. Depenta Importa any inju		21. Signature of Funeral Service Licens	90 /	n)//	22. Name and Addr Bradsh	ess of Fecility	Thin area	llome	, 11	aryrana
П	205 2 2		Mary Beth Brad	lshaw-Prut	it					Ma	ryland 2181
			23a. Pert1. Enter the disease, or composhock, or heart failure. List only o	lications that caused one ceuse on each lir	the death. Do r	not enter the mode of dy	ing, such as cardia	c or respiratory ar	rest,	,, ,,	Approximate Intervel Between
Sec. 1	Physician										Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	a	AS	CVD				-	
		er			Due to (or as a	consequence of):]	
	d d ansit	min		b	Due to (or as a c						
o Î	an an iriel-tr	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a c	onsequence on.					
68/6U,	rificete be executed in physician and as the buriel-transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a c	onsequence of):					
ŏ		M/ug		d						-	
P.O. Box	The law requires thet the death centered has been signed by the ettendingage 2 should be detached for use	sicia	Part II. Other elgnificant conditions con	ntributing to death bu	ut not resulting in	the underlying cause gi	ven in Part I.	23b. Did t	obecco use cor	tribute to	the cause of deeth?
	net the d by ti letach							1 🗆 1	ree 2 No	3 Prob	ably 4 🗆 Unknown
Š,	ires the signed by the control of th	l by							1		
Ö	w require been signature	Completed						24a. Was a		ava	re eutopsy findings illeble prior to npletion of cause
e E	e law has t	ш									leath?
	Physician: The law this certificete has ral director, page 2		05.116					1 □ Y	/\	1 🗆	Yes 2□ No
5	siciar certii irectc	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	0 TENO	Ottor Ot	hor:	ath (Check only or			
0	Phy eral d	 -	27. Manner of Death	12 Inpaties 28a. Date of Injur (Month, Day		ime of 28c. Inju	4 U Nursing F	lome 5 ☐ Resid)
<u> </u>	ath. :: Afte e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Ir		rk?]Yes 2□No		, ,		
Division of Vital Records,	al or Attending Pt s efter death. si Director: After the ed in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ury - At home, far	rm, street, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	Route Number,
	To the Hospital or Attending Physician: within 24 hours eiter dealt set of the Funerel Director. After this certifice completely filled in by the funeral director.	edical C	29a. Certifying Physical Certifying Physical Exemination (Check only one)	sicien: To the best of ner: On the basis of and manner sta	examination and	, death occurred at the ti Vor investigation, in my	me, date and place opinion, death occu	e, and due to the corred at the time, co	cause(s) and ma date and place, a	nner as stand due to	eted. the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number	1	29d. Date signed	(Month, L	Day, Year)
	-			n+	-9	D.	480918		1)15	120	07.
,			30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type, Print)			1		
	155-0		Vijay Ka	rumbunath	an, M.D.	- 201 Hal	l Highway	- Crisf	ield. M	arvla	and 21817
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		J1			7	
*	Registr		JAN 1 7 2	1007	eur to	Sperk					
NHM	IH 16 Rev 6/9	0									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Earl F. McKenzie Jan 12 2007 11:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Devlin Manor Health Care Fac. Alleq. Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**∑**M 2□ F Director 217-01-9517 9-3-1919 MD. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23s or 28s-f show the Modical Examiner must be notified at 1 XYes 2 No Director Alleq. MD. Westernport 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21562 USA 223 Poplar St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 17 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2♥ No Specify: White Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ₩idowed 4 Divorced 42 - 4516a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Fine Papers 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be Guy McKenzie Ada Stuby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary C. Fanelli 14206 Canal Rd. S.E. Cumberland, MD 21502 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite eny injury or ot 0058. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 1-18-07 Westernport, MD 22. Name and Address of Facility Fredlock Funeral Home 21. Signature of Funeral Service Licenses 31 Jones St. Piedmont, WV 26750 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hisease Immediate Cause (Final Coronan ler **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To the Funerel Director: After this certificate has been signed by the attending physicien completely filled in by the funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year) D0033286 Jan 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OVA Sunil K. Gupta, MD, 625 Kent Avenue, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 16 Registrar 200 DHMH 17 Rev 1/2001

			1 _ State	State of Maryland		rtment of			2007	02301		
			Registrar 1. Decedent's Name (First, Middle, Last)				Douin	2. Date of Death	J. No.4 U U /	3. Time of Death		
	Physici	an	James	Lee			Moore	Month	Day Year 13 2007	ο 11 Δ μ		
die.	/Medio Examin		4a. Facility Name (If not institution, give st			4b. City. Town.	Moore or Location of Deal	th L	13 2007 4c. County of Deat			
1	Exami	ei	Peninsula Regional	Madical Center	-	5	plisbuild		HICOM			
	Funeral	4.50	5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Yea			9. Birt	hplace (State or Foreign		
	Director		222-26-7444	^{M 2□ F} 63	Yrs.	Months Day	s Hours Min.	(Month, Day,) 2-2-1943		_{untry)} aware		
	p ,		Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	oum or lo	ti						
	anyla •hov	_	10a. State 10b. County	Toc. City, 1	OWIT OF LO	ation				10d. Inside City Limits 1X☐ Yes 2 ☐ No		
	Ne M	Director	MD Wicomico 10e. Street and Number	Del:	mar	104 7:- 0-4-		100	Olainen ed Mines O			
	hours after death with the Maryland ture!; or iteme 23s or 28e-f ehow al Examinar must be notified at	ă				10f. Zip Code		100	g. Citizen of What Co	untry?		
	eath	Funerai	8747 She11 Road	2. Was Decedent Ever in U.S.	13 V		1875	Specify Yes or No-	USA 14. Race - Ame	ncan Indian		
	ter d	Ë	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No			Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Black, White			
93	urs a	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐Yes 2Ã N	o Specify:		Specify: Wh	ite		
0-0	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade		6a. Deced	ent's Usual Occ	upation e during most of wo	16	6b. Kind of Business/	Industry		
2	within ene. then "	ig	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use reti	red)	, Airig				
2	filed wi Hygien Sther th	ပ္ပ	11		Forem	an			Tree Serv	ice		
nd	0 = 0 >	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma				
78	2 should be and Mental ie marked o eumatic eve	유	Harry Washington M					arguerite				
Maryland 21215-0036	12 st h and 7 ie n treun		19a. Informant's Name/Relationship (Typ						City or Town, State, 2	(ip Code)		
	1 end 2 Health a em 27 is		Lydia Pearson - Pe		19/4 of Dispos	Pine Wa sition (Name of	y, Salisb	ury, MD 2	L804 Dc. Location - City or	Town, State		
Baltimore,	ages int of t: if it		1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	etery, crem	atory or other p	dace) 7 Gds 1-1		•			
Ħ	nit. Partme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	ebron, Man	ryland							
Ba	permit. Pages 1 and 2 should b Deperment of Health and Menic importent: if Item 27 ie marked eny injury or other treumatic e pnce.		Malling The	111 Rho		Name and Add	D	ounds Fund				
			23a. Party. Enter the disease, or complic shock, or heart failure. List only on	gions that caused the death. I	Do not ente	r the mode of d	<u>IN Street</u> ying, such as cardia	 Sallisbilit c or respiratory arres 	ry, MD 218	Approximate		
	Physician		Immediate Cause (Final							Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	Due to (or as a consequent	ce of):		-			Days		
н	Examiner			Multila	bar	Pne	umoni	a		Dave		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce orj:	,,,,	- VL 77 71			6.5		
	ocuted nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
00	e exe Sien e urial-	Ë	resulting in death) Last	Due to (or as a consequent	ce of):							
8760,	the death certificate be executed y the ettending physicien end Iched for use as the burial-transit	dicai	d.									
9 x	eath certific ettending p I for use as	Me	IF FEMALE:	o If was outcome of programs			**					
Вох	ettend for us	ian	in the past 12 months?	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death	ath 3	Ectopic pregnan Other (specify)	су		23d. Date of deli Month	very Day Year		
P.O.	thet the de ed by the detached	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	1 3	Other (specify)						
	res thet the igned by be detacted	Y P	Part II, Other significant conditions cont	ributing to death but not resultin	g in the un	derlying cause o	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
ds	law requires thet es been signed b 2 should be deta	d by	Congestive A	eart Failure	_			1 ☐ Yes	2 000 3 □ Pro	obably 4 Unknown		
Ö	w requir	Completed	Renal Failur	L · COPD)			24a. Was an	24b. Were au	topsy findings available		
Re	و ع و	E	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7)				autopsy performe	prior to death?	completion of cause of 2□ No		
ta	ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath Check only one	SPN0 ILL Tes	2L N0		
>	Physician: this certific ral director,	ToE	examiner? 1 ☐ Yes 2 SNo	spital: 1 ⋈ Inpatient 2 ☐ ER/	Outpatient	3□ DOA C	ther		ce 6 □Other (Spec	cify)		
0	ng Ph her th nerai		27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer) 28	b. Time of Injury	28c. Inj	ury at ork?	28d. Describe how	injury occurred			
Si	Attending r death.	atic	2 Accident investigation				∏Yes 2 □No					
Division of Vital Records,	of or Attendir after death. I Director: Af d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, offic	9	28f Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,		
	Hospitel or 4 hours afte Funeral Dire tely filled in b		no- continu									
	Hos 24 ho Fune stely f	edicai	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination and manner stated	dge, death and/or inv	occurred at the estigation, in my	time, date and place opinion, death occi	e, and due to the cau urred at the time, date	se(s) and manner as e and piace, and due	stated. to the cause(s)		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director.	Me	29b. Signature and Atterof certifier		0	29c. Lice	nse number	290	I. Date signed (Monti	n, Dey, Year)		
			1/1/4	Some N	ib	D	5-5-427	1.7	1	3 2007		
	(D)		30. Name and address of person who con	apleted cause of death (Item 23	a) (Type, I	Print) /	16 M) /for0	(34	virially (1, 2007		
	120		A	NO C/o Delmary	ra Hea.	ALLL	Suite 60.	5 Sali	chary MD	21801		
	Sta		31. Date filed (Month, Day, Year)	32. Hegistrars Signature	,	,						
	Registr	ate										

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryland		rtment of h			iene og. No20	07	02302
Physic /Med		Decedent's Name (First, Middle, Last) Ronald Wayne					2. Date of Deat Month JANUARY	Day / 4	2007	3. Time of Death
Exami Funeral	ner	4a. Facility Name (If not institution, give st	Medical (8 7. Age (In yrs. la	nfy ast birthday)		or Location of Dec 1 USBUN If Under 24 H Hours Mi	rs. 8. Date of Birth		Hosn	ace (State or Foreign
Director		212-50-5040 Usual Residence of Decedent 10a. State 10b. County	M 2□F 60	Yrs.			10/18/		Mar	yland d. Inside City Limits
the Maryi	Director	Maryland Wicomic	0 W	illard	S 10f. Zip Code		1	Og. Citizen of		1 K Yes 2 ☐ No
deeth with	by Funeral DI	7408 Main Street	2. Was Decedent Ever in U.S	S. 13. V	218 Vas Decedent of N Yes, specify Cub	Hispanic Origin?	(Specify Yes or No-		ce - America	
1215-0036 within 72 hours after deeth with the Maryland ene. than "natural, or items 23a or 28s-f show the Madical Examiner must be notified at	d by Fu	1 Never Married 21 Married 3 Widowed 4 Divorced	1 K Yes 2 □ No If Yes, Give Year or Dates: 1966—	4	☐ Yes 2X No	Specify:		Specif	y: wh	nite
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Dependent of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f show eny injury or other treumatic event, the Madical Examiner must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	ent's Usuat Occup kind of work done OO NOT use retire 'ity Guar	during most of w	rorking	16b. Kind of B Amusem		_
yland ould be file Mental Hy arked othe	To Be C	17. Father's Name (First, Middle, Last) Charles Gore					ame (First, Middle, M a Wisner	Aaiden Surnan	ne)	
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Sylventer of the property of the private of the pri	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	ence of):	ial he Co	hefa	refio ug Dis	reas	e	Initerval Between Onset and Death
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Division spital or Attending ours efter death. Heret Director; After	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify		eet, factory, office		28f. Location (St City or Town		ber or Rumal	Route Number,
To the Hospital within 24 hours or To the Funerel completely filled	edical	one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inv	estigation, in my	opinion, death oc	curred at the time, d	ate and place,	and due to	the cause(s)
Son Son	×	29b. Signature and title of certifier	intl 0	Kee	29c. Kicen		2	9d. Dat/ signe	d (Mohth, E	Oay, Year)
2011	ate	30. Name and address of person who cor Senjamin H. MON/ 31. Date filed (Month, Day, Year)	npleted cause of death (Item 400 E., 32. Registrar's Signat	carres	rint) 4.	SA49	shif no	_/		
Regis		5.0	107 Magues	H. A	parte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** eraldine 3 2007 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner At the Wicomico Isbun 20 HO3 pice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2**X** F Yrs. Director 214-36-5431 66 January 14, 1940 Washington DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XX No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31740 Kenilworth Drive 21804 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify. 2 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Parks 2 Cora Mae Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 i Richard Mason (Husband) 31740 Kenilworth Drive Salisbury, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o ō 01-18-2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hebron, Maryland 4 □Donation 5 ☑Other (SpecifyEntombment Springhill Memory Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Short Funeral Home Delmar, DE 3 E. Grove Street 23a. Part1. Enter the disease, or configurations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death METAS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ası IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ pe 1 ☐ Yes 2 ☐ No 3 robably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Inpatient ဥ 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA the Funeral Director: After this appletely filled in by the funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred the Hospital or Attending Natural Injury 5 Pending 1 ☐ Yes 2 □ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 00058410

Registrar

State

31. Date filed (Month, Day, Year)

ORIGINAL

DWWOOD CT. SALISBURY NO 2180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26266

		-	For State	State of	Marylan		artmen rtificate			and M	lental Hy	/	007	02304
-			Registrar 1. Decedent's Name (First, Middle,	l astl		Ce	Tillicate	9 01 L	Jeani		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia										Month Januar	v 7	2007	0105 M
	/Medic Examin		George W. New 4a. Facility Name (If not institution, g		oer)		4b. City,	Town, or	Location of		Janaar	-	ounty of Deat	
1	Examin	Ç1	412 Secluded E			ot C	(31en	Bur	nie		An	ne Ar	unde1
- ·	Funeral Director				. Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day NOV 8	y, Year 1	9. Birt 9 V 1	hplace (State or Foreign rginia
	yland now		Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	B Mar	cto	Texas Jeffe	rson	P	ort A								
	or 28	Director	10e. Street and Number	_			10f. Zip		4.0			-	n of What Co JSA	ountry?
	s 23s	ral	1649 Gulf Way	Dr.	ent Ever in II	S 13		7764		gin? (Sp	ecrify Yes or No		. Race - Ame	erican Indian,
9	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow Is Medical Examinar must be molifiad at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	d 1 X Yes 2	es? ! 🗌 No		If Yes, spec		n, Mexicar		ecify Yes or No Rican, etc.)		Black, Whit pecify: B]	
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/ar	0 to 0	To B	Unobtainable								eward			
Maryland	and and s m	1 9	19a. Informant's Name/Relationshi								al Route Numbe			
	1 and 2 Health tam 27		Dwight N. New	man(Son)		412 Place of Disp			a Po		Date		ation - City or	en Burnie,
Baltimore,	ages 1 au nt of Hea : If itam or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3		tate	etro C	matory or o	ther plac			0-07			e, Md.
Itim	permit. Pages Department of Pages Important: If its any injury or of once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		rie				4		Morti			
Ba	permit. Departr Imports any inj		Larry S.	1	6048						napolis			
X.			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that ca	used the deat		nter the mod	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
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	/Medical	ġ.	resulting in death)		or as a conseq									100100
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	9d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (d	or as a conseq	juence or):		ומ	1110	517				
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68	ifficate g phy as the													
Box	h cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnath 2 Peta		□Ectopic p	regnancy	,			23	d. Date of de	elivery Day Year
_	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregna 9□ Unkno	ant at time of o wn	death 5	Other (s	pecify) _					INIONAT	Day . Gai
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o u	E ja a	on:	27. Manner of Death 1 Natural 5 Pending		of Injury h, Day Year)	28b. Time Injury	of M	28c. Injui Wor	ryat rk? ∣Yes 2.[INO.	28d. Describe	now injury	occurred	
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	o the ithin 2 o the	Med	29b. Signature and title of certifier				29	c. Licen:	se number			_		nth, Day, Year)
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			30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Typ	e, Print)							21096
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Ä.	Regis	rar	JAN 1	1 2007		A A								

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Physicia Medical Examin	n/	Registrar 1. Decedent's Name Chidiet	e (First, Middle,L ere	ocl	nulo				1 1	Date of Death Month anuary 1,	Day Ye	ar	3./Time of Death 3 0245 hrs
grand)		4a Facility Name (if		give street and nu	umber)		4b. City, Town, or Burtonsville		Death		4c. County Montgo		·
Funeral Director		5. Social Security N 225 -77-4	.000	Sex	7. Age (In yrs	last birthday) Yrs	If Under 1 Year Months Day			Date of Birtl		Foreig	hplace (State or n Nigeria untry)
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eath with th	— L	11. Marital Status	ed 2 X Marri	12. Was De	cedent Ever in orces?	lf Y	s Decedent of Hi es, specify Cuba	spanic Origin			14 Race		can Indian, Black,
ours after d atural", or <u>xaminer m</u>	b F	3 Widowed 15. Decedent's Ed		ed If Yes, Give Ye or Dates: only highest gra	de completed)	1 16a. Deceder	Yes 2 X No	tion (Give kin			16b. Kind of B		ndustry
0036 within 72 h giene her than "n	Completed	Elementary/Second 17. Father's Name		4	1-4 or 5+)		istered	Nurse				ente	n Hospital
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Dis 1 X Burial 2 4 Donation 5	Cremation Other Spec	ify:	rom State	crematory or ot Family Co	emetery		01-2	4-2007	Nige	ria	me, Inc.
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Physician /Medical Examiner		23a. Part I Enter th failure. List on Immediate Cause (or condition resulting	ly one cause on Final disease		ce Injuries		he mode of dying	, such as card	diac or re	spiratory arre	st, shock, or he	eart	Approximate Interval Between Onset and Death
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50, te be executed ysician and burial - transit	ledical	UNPENDED		AMENDED	outcome of or	regnancy					23d. Date of	of delivery	
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Fo the Hor vithin 24 h Fo the Fu	Medical (4-	Medical Exami		of examinatio	ledge, death occu in and/or investiga	tion, in my opinio	n, death occu			and place, and	due to th	e cause(s)
	Σ	29b. Signature and	title of certifier	11.211				se number			29d. Date sig January 2		nth, Day, Year)
CR(3)		30 Name and add Pamela E.	ress of person with Southall, MD		use of death (I		1 Penn Stree	et, Baltimo	ore, MD	21201			
St. Regist	ate rar	31. Date filed (Mon	6 2007	Lever 32 F	Registrar's Sign	Specks.							
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State of Maryland / Department of Health	
1- State Criticate of Death Certificate of Death	/
Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
Pantelis Pispiris Medical Pantelis Pispiris	January 7, 2007 12:10A M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	
Heritage Harbour Health & Rehab. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director 216-36-9738 5. Social Security Number 216-36-9738 6. Sex YZM 2 F 84 7. Age (In yrs. last birthday) 1 Under 1 Year IT Under 1	Min. (Month, Day, Year) Country) July 27, 1922 Greece
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland Anne Arundel Annapolis	1/□ Yes 2 □ No
10e. Street and Number	10g. Citizen of What Country?
10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 10a. Street and Number 10b. Street and Number 9 German Street 10b. Street and Number 10b. Zip Code 21401 11. Marital Status 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	United States
12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No- an, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
All House Polices 7 1	specify: White
The state of the s	st of working 16b. Kind of Business/Industry
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Chef Its part of the part of	ner's Name (First, Middle, Maiden Sumame)
L 52g 5 W Hrknown Hrk	nown
Tr. Father's Name (First, Middle, Last) Unknown 19a. Informant's Name/Relationship (Type, Print) Nicholas Kallis / Friend 18. Mott Unk 19b. Mailing Address (Street and Number) 19b. Mailing Address (Street and Number) 19c. Mailing Address (Street and Number)	ber or Rural Route Number, City or Town, State, Zip Code) et Annapolis, Maryland 21401
C # 01 F	Date 20c. Location - City or Town, State
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21. Signature of Funeral Service Licensee 22. Name and Address of Faci	John M. Taylor Funeral Home, Inc.
rectar of som	oucester St. Annapolis, MD 21401
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	s cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) Medical Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	
Examiner	
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O to the property of the prope	28d. Describe how injury occurred
To Vital For Part of the Part	28f. Location (Street and Number or Rural Route Number, City or Town, State)
27. Manner & Death Solution Column	
29a. Certifier 2/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only 2/1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, do	and place, and due to the cause(s) and manner as stated. eath occurred at the time, date and place, and due to the cause(s)
one) and manner stated. 29c. License number 29c. License number	r 29d. Date signed (Month, Day, Year)
D577	796 01-02-0,1
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	iAnnapolismo 21401
State Registrar JAN 0 9 2007	•

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Dav Edith Jackson Parker January 14, 2007 0830 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F 218-05-4688 89 Director Feb. 12, Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 Stayman Drive 21904 II.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after ☐Yes 2 🖾 No f Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 X Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland Transportation 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Authority Hatem Bridge Twelve Years Sgt./Toll Collection Perryville, Maryland marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental John E. Jackson, Sr. Laura Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 99 item 27 l Emerson L. Jackson (son) 196 Firetower Road, Port Deposit, Maryland 21904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1 € Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Mark's Cemetery 01/17/07 Perryville, Maryland Lee A. Patterson & Son Funeral Home, P.A. 21. Signatyre of Funeral Service Licensee Inmers. Perryville, Maryland 21903-0766 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 951 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No ō Day 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Tes 2X No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: di. 2 1 ☐ Yes 2 No ursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 ☐ Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗌 Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lemas 30. Name and address of person cause of degistrar's Signature State Registrar

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altimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or items 23e or 28e-f show entry injury or other treumetic event, the Medical Examiner must be righted at once.	by Funeral	11. Marital Status 1 □ Never Marr 3 ➡ Widowed		If Yes C	Forces? 2 12 12 Sive			Vas Decedent of Yes, specify Cu □ Yes 2∏ No			ecify Yes or N Rican, etc.)	E	Race - Ame Black, White cify: Whi	
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Baltimore,			20a. Method of Disposition 1 Durial 2 Crema	ion 3 🗆 F	lemoval from S		Place of Dispo	matory or c	other plac		-	Date	20c. Location			
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) lanuar RONALD LEE RANDALL 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Min. Months Days Hours 1**∑** M 2□ F Yrs 214-60-3087 MARCH 23 1954 WASHINGTON, DC Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10b. County 1X Yes 2 □ No PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 4520 LORDS LANDING ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No ARMY If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BLACK Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL POLICE GOVERNMENT 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM RANDALL ROSA ROBINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WILLIAM E. RANDALL/BROTHER 1625 ROOSEVELT AVENUE LANDOVER, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/17/2007 MARYLAND VETERANS CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or its a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Tes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

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Funeral

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Baltimore, Maryland

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> Examiner burial-tran attending physician the as use a for the signed by to been page 2

requires that the death certificate be executed

The law

Physician:

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Certification:

Medical

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

State Registrar

25. Was case referred to medical examiner? 1 ☐ Yes 2**₹** No

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

🛮 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10mas

31. Date filed (Month, Day, Year)

JAN 1 6 2007

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

			State of Maryland		artment of rtificate o		and Me		0.0	07	0001		
Ę	Physici	an	1. Decedent's Name (First, Middle, Last) Linda Reeves		imouto o	· · · · · · · · · · · · · · · · · · ·		. Date of Deat Month	Day	Year	3. Time of Death 6:00p M		
Sept.	/Medic	_	4a. Facility Name (If not institution, give street and number)		4b. City, Towr	n, or Location of		Jan.	5, 20	07 f Death	0.00p		
1	Examin	er	305 Ternwing Drive		•	Arnold			1		rundel		
	Funeral Director		5. Social Security Number 102–46–5471 6. Sex 1 M 2 → 7. Age (In yrs. It	la <i>st birthd</i> ay) Yrs.	If Under 1 Ye Months Day		Min.	Date of Birth (Month, Day, Sep. 17	Year) , 1954	9. Birthpl Coun	lace (State or Foreign try) NY		
	show	'n	Usual Residence of Decedent 10a. State	, Town or Lo		nold				10	0d. Inside City Limits 1 ☐ Yes 2 No		
	with the IV a or 28a-f be notified	Director	10e. Street and Number 305 Ternwing Drive		10f. Zip Cod	e 21012		1	0g. Citizen of WI	nat Coun			
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 11 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	of Hispanic Ori Cuban, Mexicar	gin? (Specif i, Puerto Ric	fy Yes or No- can, etc.)	14. Race Black Specify:	- America	etc.		
Baltimore, Maryland 21215-0036	within 72 ho ene. than 'natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	(Give	lent's Usual Oc kind of work do DO NOT use rel Navy Ba	ne during mos tired)	t of working		16b. Kind of Bus		austry Academy		
and 2	should be filed withir nd Mental Hygiene. marked other than imatic event, the Me	Be	17. Father's Name (<i>First, Middle, Last</i>) Clarence W. Reeves, Sr.		navy 2	18. Mothe	r's Name (F		Maiden Surname				
Maryl	and 2 should lealth and Men m 27 is marke her traumatic	2	19a. Informant's Name/Relationship (Type. Print) Clarence W. Reeves, Jr./Bro.			Route	52, N	arrows	; City or Town, S burg, NY		Code) 2764		
more,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		I Dunai 2 KN Cremation 3 Line pevaritom State		sition (Name of natory or other) Cremator	place)	Jan. 2007	[°] 9,	20c. Location - C	-			
Balti	permit. Departm Importar any Inju	4 Donation 6 Other (Specify) Metro Crematory 2007 Baltimore 21. Signature of Funeral Service Licensels Barranco & Sons, P.A. Severna Park F 495 Gov. ritchie Hwy, Severna Park,											
	Physician		23 and Enter the disease, or our lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List any one cause on each line.										
	/Medical Examiner	(resulting in death) Due to (or as a consequ	1	J								
	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	,									
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence) d.	ience of):									
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	ideath 3□	Ectopic pregna				23d. Date Mon		ry Day Year		
ds, P.	tw requires that s been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resu	ılting in the ur	nderlying cause	given in Part I.		23e. Did tot		oute to th	e cause of death?		
Division or Vital Records,	The law requate has been page 2 shou	Completed	Dyslipidemiq					24a. Was a autops perfor	red2 de	ior to con eath?	osy findings available npletion of cause of		
ţa		a)	25. Was case referred to medical			26. Place	of Death (1□ Yes : Check only on		Yes	2∐No		
<u>r</u> <	S S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien	COLDON		rsing Home	5 Reside	ence 6 □Othe	(Specify)		
sion c	ding h. After fune		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	28b. Time of Injury		njury at Work? I□Yes 2□		d. Describe ho	ow injury occurre	d			
Divi	or A fler (Direction by	Certification:	4 Homicide determined 256. Place of injury A No building, etc. (Specify	y)				City or Town					
	thin 24 hours at the Funeral I	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner: On the basis of examinat and manner stated.	wiedge, death tion and/or in	n occurred at the vestigation, in n	e time, date an ny opinion, dea	nd place, an ath occurred	d due to the c	ause(s) and man late and place, a	ner as st nd due to	ated. the cause(s)		
	To the within 24	Ž	29b. Signature are vitle of certifier			ense number	6817		9d. Date signed				
•			30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	, UT	0012	^	-7114	70)	2007		
	Sta	ate.	Kevin J. Brown, M 31. Date filed (Month, Day, Year) 32. Registrar's Signar	ture	250 V	Nood	Rd .	Hana	polis,	ms	21402		
	Registi		31. Date filed (Month, Day, Year) 9 ZUU 32. Registrar's Signal	B A	nout!								

Amended Item 5 per F.D. 01/16/2007 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 **Physician** Kenneth Lavern Ruby, Sr. 11 6:57 P. M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4715 Maple Grove Road Carroll Hampstead If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 2 16 ial 14 uris 94 per **Funeral X**□M 2□ F 19 14 6947 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 10a. State 10b. County 1 ☐ Yes 2 XNo Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 is marked other then "natural", or items 23a or traumatic event, the Medical Examiner must be a 4715 Maple Grove Road 21074 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 tt Styles 2 □ No 1942— If \$8s, Give Year or Dates: 1945 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Painter/Paper Hanger Painting Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Alver Eugene Ruby Elsie Lucretia Hilker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Tracey - Daughter 4715 Maple Grove Road, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation Hampstead, MD 1/16/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sleven Eline Funeral Home, 934 S. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LUNG CANCO Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ettending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probably 4 Unknown Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, to 25. Was case reterred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29c. License number 29d. Daye signed (Month, Day, Year) WI IOTIVA 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 16

101

200

32. Registrar's Signature

555 South Center St.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036

Phy: /Mc Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division or Vital Records, P.O. Box 68760,

		For Stete	Stat	e of Ma	ryland		artmer <i>rtifica</i> i				ental H			0 0		0.1.1
		Registrar 1. Decedent's Name (First, Mi	ddle, Last)			Ce	lillicai	e or i	Jeani		2. Date of I	Reg. No Death	2	111	3. Time o	Death
hysici: /Medic		June Florence									Jan. 1	12, ^{Da}	ў 007	Year	4:30	A ^M
/wedic Examin		4a. Facility Name (If not institu		d number)					Location	of Death				y of Death		
		704 Midway Dri		17.4				deri r 1 Year		r 24 Hrs.	0 Data at 1		rede	rick	-1 (0)	
uneral rector		5. Social Security Number 219–12–0639	6. Sex 1 ☐ M 2 X		86	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of l (Month, Aug.	Day, Year) 12,19	20	Сои	place (State ontry) sylvan	
ow It		Usual Residence of Decedent 10a. State 10b. Cou			10c. City,	Town or Lo	ocation					-		T	10d. Inside C	ity Limits
a-f sh	tor	Maryland Free	derick		Fre	deric	k								1 X Yes	2∏No
23a or 28a st be not	Funeral Director	10e. Street and Number 704 Midway Dr	rive	,			10f. Zi 217	Code				10g. Cit		What Cou	intry?	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ N 3 ☑ Widowed 4 □ Divor	Armed 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent E ed Forces? Yes 2 N s, Give or Dates:			Was Dece If Yes, spe 1 ☐ Yes	cify Cuba	ispanic On an, Mexica Specify	an, Puèrto I	cify Yes or Rican, etc.)	No-		ck, White	can Indian, , etc. ite	
than "naturi e Medical E	Completed		dent's Education ghest grade comple 2) Colle	ted) ege (1-4or 5-		16a. Dece (Give life. Homem	kind of wo DO NOT L	ork done	durina mo	st of worki	ng		ind of B	Business/Ir	ndustry	
ther t		17. Father's Name (First, Mide	dle, Last)			пошеш	akei		18. Moth	ner's Name	(First, Midd					
rked o	To Be	Eber Ove									Baker					
27 is ma er trauma		19a. Informant's Name/Relati James N. Rhote		son							ad, Tl					21788
ant: If item ury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Othe		from State	ce	nce of Dispo metery, cre haven	matory or Memo	otherplac rial		1-15-		Fre	deri	lck,	own, State Maryla:	nd
importa any Inji once.		21. Signature of Funeral Services	rice Livensee	lle	Dli						uffer ke, F				yland	21702
		23a. Part1. Enter the disease shock, or heart failure.	e, or complications List only one cause	hat caused on each lin	the death. e.	Do not en	ter the mo	de of dyin	ig, such a	s cardiac o	r respirator	y arrest,			Approxima Interval Bel Onset and	tween
sician		Immediate Cause (Final disease or condition resulting in death)	a			nia									Oriset and	Death
edical miner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Cay est be leaved for luy the leaves of the large form of the lar														
physician and the burial-transit	dical Examin	cause (Disease of injury that initiated events resulting in death) Last	c	e to (or as a	a conseque	nsequence of):										
as th	o P	IE EEMALE.														
To the Funeral Director: After this certificate has been signed by the attending t completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	s, outcome p live birth Pregnant at Unknown	2 Fetal	death 3	⊒Ectopic p ⊒ Other (s		′			1974		ate of deliv	•	Year
signed b	þ	Part II. Other significant con	ditions contributing	to death bu	it not resul	ting in the u	ınderlying	cause giv	en in P <i>a</i> rt	1.			use con	tribute to	the cause of obably 4	death? Unknown
ate has been bage 2 shou	Completed										24a. W au pe	utopsy erformed?	m	Were aut prior to co death? 1 □ Yes	opsy findings ompletion of c	available cause of
ctor, 1	Be C	25. Was case referred to med examiner?							26. Plac	e of Death	(Check on					
this coal dire	은	1 Yes 2 No	Hospital:	1 Inpatie		R/Outpatie			4 🗆 N	lursing Hor		esidence			ity)	
After	ion:	27. Manner of Death 1 Natural 5 Pe		Date of Injur (Month, Day		28b. Time o Injury	M	28c. Injur Worl	yat k? Yes 2[28d. Describ	oe how inju	iry occui	rred		
il Director: ed in by the	Certification:	3 Suicide 6 □ Co	uld not be 28e.	Place of inju building, etc					163 2			n (Street al Town, State		ber or Rui	ral Route Nun	nber,
he Funera Dietely filie	Medical C	29a. Certifier Certifier (Check only one)	ifylng Physiclan: 1 ical Examiner: On and	o the best of the basis of manner sta	examinati	/ledge, dea on and/or in	th occurred	d at the tir n, in my c	me, date a	and place, a	and due to t ed at the tin	the cause(s	s) and m	nanner as , and due	stated. to the cause(s)
To th	M	29b. Signature and title of cel	tifier M	>			25)c. Licens	e number	041	7	29d. Da) Z	ed (Month	, Day, Year)	
		1	son who completed	100.0	650	c Tl	Print)	as	Joh	nser	1 >1	r, 1	VE	deni	21 C/L 1	762 40
Sta Registi		31. Date filed (Month, Day Y	1 6 2007	32. Straistra	ar's Signati	B 1	porc	_^^								

		1	For State Registrar	State of M	laryland i		artment of H tificate of L		nd Mental H	Reg. No.	. U U /	02315
	Discolati		1. Decedent's Name (First, Middle, L.	ast)					2. Date of D Month	Day		3. Time of Death
	Physicia /Medic		Norman Cartier	Regnier					Januar			6:25 P. M
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of	Death		County of Dea	ın
			Garrett County M			bioth do. d	Oakland If Under 1 Year	If Under 2	4 Hrs. 8. Date of B		arrett	thplace (State or Foreign
П	Funeral		o. ooo.a. o. o. o. o. o. o. o. o. o. o. o. o. o.	Sex 7. A 1521 M 2 □ F	ge (In yrs. last	Yrs.	Months Days	Hours	Min. (Month, I	Day, Year)	C	ssachusetts
	Director	-	Usual Residence of Decedent		84				Julie	20 13	722 Ma	ssachusetts
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	Mary f sh	ğ	MD Garret	t	Oak	1and						1 □ Yes 2√ No
	the	<u>e</u>	10e. Street and Number		Journ		10f. Zip Code			10g. Citi	izen of What C	ountry?
	n with	by Funeral Director	1893 Paradise Po	int Road			21550			Uni	ited St	ates
	death	ner	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S.	13.	Was Decedent of Hi	spanic Origi n. Mexican.	in? (Specify Yes or Neuron Rican, etc.)	10-	14. Race - Ame Black, Whi	
9	after or ite	Ē	1 ☐ Never Married 2 Married	1 ☑ Yes 2 ☐	No		**	Specify:			Specify:	
8	72 hours after death with the Maryland naturel; or Items 23s or 28s-f show disal Examiner must be notified at		3 Widowed 4 Divorced	Year or Dates	WWII					1 101 15		hite
21215-0036	72 h natu	Completed	15. Decedent's (Specify only highest g		1	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most	of working	160. K	ind of Business	vindustry
121	within ene. than "	dw	Elementary/Secondary (0-12)	College (1-4o	r 5+)		pervisor	/		Ot	cis Ele	vator
	filed withi Hygiene. other than		17. Father's Name (First, Middle, Las	Zst)		_ Sul	PELVISOL	18. Mother	's Name (First, Midd			vacoi
anc	ntai hed o	Be c			gnier			Louis	s e	Tot	ırville	
Maryland	should be ind Menta! I marked o	၉	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street a		or Rural Route Num			Zip Code)
Z Z	d 2 sho th and t7 is mu trauma		Victoria Regnie			1893	Paradise	Point	Rd., Oak	land.	MD 21	550
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene it Health and Mental Hygiene item 27 is marked other than "neturel", or items 23a or 28a-1 show other traumatic event. The Medical Exercises must be notified at		20a. Method of Disposition	I, WIIC	20b, Plac	e of Dispo	sition (Name of matory or other place	!	Date	20c. Lo	ocation - City or	Town, State
D D	ages ant of t: If i		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		0		Memorial	1	1/17/07	Oal	kland,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lic		Journ		2. Name and Addres					
Ba	Depa Impo any is		Karaune	V weither				21 N.	Second St			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that oaus	ed the death.	Do not en	ter the mode of dyin	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final			- 1 1 -	tion					Onset and Death 2 ½ Vrs
	/Medical resulting in death) Due to (or as a consequence of):										2 3 915	
н	Examiner		Conventially list conditions	Periph	neral	vasc	ular di	sease	=			2 ½ yrs
	D =	ğ	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or a	is a consequer	nce of):						
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Ö,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Ä	resulting in death) cast	Due to (or a	is a consequer	ice on:						
8760,	ate b	Physician/Medical		d								
9 ×	ertific Jing p	/We	IF FEMALE:	23c. If yes, outcon	ne of pregnanc	v			1.00		23d. Date of de	alivery
Вох	that the death certifica ed by the attending ph detached for use as th	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetel de at time of deat	ath 3	□Ectopic pregnancy □ Other (specify)				Month	Day Year
-	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		50						
P.O.	that ted by	F.	Part II. Other significant conditions	s contributing to death	but not resulti	ng in the u	inderlying cause giv	en in Part I.	23e. Di	d tobacco	use contribute	to the cause of death?
ds	uires sign Id be	d by							1[Yes 2	Mo 3□F	Probably 4 Unknown
50	w requires that s been signed E s should be deta	Completed							24a. W		24b. Were a	utopsy findings available
Re	The faw ate has I page 2 s	mc							au pe 1 □ Yes	topsy rformed? 2 20 No	death?	completion of cause of
ā	ificati or, pa		25. Was case referred to medical					26. Place	of Death Check on		,	5 22.10
<u>=</u>	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	itient 2 🗵 EF	VOutpatie	nt 3 DOA Oth	er: 4 □ Nur	sing Home 5□Re	sidence	6 ☐Other (Sp	ecify)
o	Phy eral c		27. Manner of Death	28a. Date of Ir		8b. Time o	of 28c. Injur Wor	y at	28d. Describ	e how inju	ry occurred	
<u>o</u>	Attending r death. ector: After oy the fune	atlo	1X Natural 5 ☐ Pending 2 ☐ Accident investigat		Jay reary	injury		Yes 2□N	lo			
Division of Vital Records,	Atte	iif	3 Suicide 6 Could not	Z86. Place of	Injury - At hom etc. (Specify)	e, farm, st	reet, factory, office			n (Street ar Town, State		Rural Route Number,
Ö	talor rs afte al Dir	Certification:		1					1			
	Hospital 4 hours a Funeral tely filled	edical	29a. Certifier 1 ☑ Certifying (Check only 2 ☐ Medicel Ex	Physicien: To the be teminer: On the basis	st of my knowle of examination	edge, dea n and/or it	th occurred at the tir evestigation, in my o	ne, date and pinion, deat	d place, and due to the hoccurred at the time.	ne cause(s le, date an) and manner a d place, and du	as stated. ue to the cause(s)
	the the	Medi	one)	and manner	stated.		29c. Licens				te signed (Mor	
	5 t to 2	~	29b. Signarure and title of certifier	PIA	×			035			1 - 14 - 1	
			towar!	ren y	68							
	at 1/A	in	30. Name and address of person wh			(スな) (Type	Print) Memorial	Dri	ve Oakla	nd	MD 21	550
	q VA	11	Donald R. Ric 31. Date filed (Month, Day, Year)		strar's Signatur		15 mor ral		vc Oukla	114,	21.	333
181	Sta Regist	ate rar	JAN 1	to the same of the	MARKE A	0	Jan St.					

				State of Maryland				-	_	
			For State Registrar				of Death		g. No. 007	02316
П	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Death Month	Day Year	3. Time of Death 4:10 P M
	/Medic	al	JAMES CARL STOV. 4a. Fecility Name (If not institution, give			4b. City. To	wn, or Location of Death	January	4c. County of Death	
	Examin	ier	2040 Franklin Ch				lington		Harfor	£
	Funeral Director		5. Social Security Number 6. Se 221–24–8332	x 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 \ Months D	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, 1/31/19	Year) 9. Birth Cou 35 Mary	place (State or Foreign ntry) 11and
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryl Inter	tor	MD Har	ford	Ι	Darling	gton			1 ☐ Yes 2 📉 No
	n with the 3e or 28	ai Director	10e. Street and Number 2040 Franklin Cl	hurch Road		10f. Zip Co	ode L034		g. Citizen of What Cou USA	ntry?
336	172 hours after death with the Maryland "natural", or itsms 23e or 28e-f show idical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 4/57–8		Was Decedent f Yes, specify	nt of Hispanic Origin? (Si Cuban, Mexican, Puert No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	etc.
2	within	Completed	15. Decedent's Edi (Specify only highest grad		16a. Deced (Give life.	dent's Usual C kind of work of DO NOT use TUCK DY	Occupation done during most of wor retired) IVEL	king T	6b. Kind of Business/Ir ransportat:	
nd 2	be filed tal Hygi d other svsnt.	To Be Co	17. Father's Name (First, Middle, Last) Walter Grover Wol.	ff Stovall, Sr.	•			ne (First, Middle, M Loretta P		
	har resu		19a. Informant's Name/Relationship (7) Linda Irene Stova				Street and Number or Ru Lin Church			
Baltimore,	0 - = 0		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ I Cremation 3 □ I Cremation 5 □ Other (Specify, I Cremation 5 □ Other (Speci	Removal from State	netery, crer	sition (Name matory or othe on Ceme	er place)		Oc. Location - City or T arlington,	
Baltir	permit. Page Department of Important: If sny injury or once.		21. Signature of Funeral Service Ligens		22	2. Name and	Address of Facility S Funeral H	ome, Inc.	, Delta, P.	A 17314
		ļ	27a Part 1 Enfor the disease, or comp shock, or heart failure. List only of	lications that caused the death.						Approximate Interval Between
	Physician /Medical Examiner		immediate Cause (Final disease or condition resulting in death)	a		16	CANCES			Onser and Death 4 YIMS
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
760, 7	te be executed ysicien and e burial-transit	cai Examin	that initiated events resulting in death) Last	C. Due to (or as a conseque	ance of):					
89	ndification of phy as the		IF FEMALE:							
P.O. Box	The law requires that the death certificate ate has been signed by the ettending physinage 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3[☐Ectopic preg ☐ Other (spec			23d. Date of delive Month	very Day Year
	w requires thet the bean signed by should be detact	Ď	Part II. Other significant conditions co	intributing to death but not result	ting in the u	nderlying cau	se given in Part I.	23e. Did tob	acco use contribute to	
Division of Vital Records,	The law re ate hes bee page 2 sho	Completed				· · · · · · · · · · · · · · · · · · ·		24a. Was ar autops perform 1 Yes 2	prior to c	opsy findings available ompletion of cause of
Vita	ysician: The is certificate hi director, page	o Be	25. Was case referred to medical examiner?	Hospital:	200		Othor	th Check only one		2.1
on of	Attending Physician: ir death. sctor: Atter this certifics by the funeral director; i	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	28b. Time o Injury		injury at Work? 1 ☐ Yes 2 ☐ No	28d Describe ho	nce 6 □Other (Spec w injury occurred	7)
Division	2 # 5 E	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ne, farm, st			28f. Location (Sti City or Town	reet and Number or Rui , State)	al Route Number,
	To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by	edicai C		ysician: To the best of my know hiner: On the basis of examination and manner stated.						
	To the To the comple	Me	29b. Signature and 11 e of certifier	. 0.1	******	29c. l	License number	29	d. Date signed (Month	, Day, Year)
			1 homes 4	. seemle N	10	1	192800		1122/0	
	15		THOMAS A. 1	5/01/100 3/6	50	Print)	Union Ar	E, HAG	, Med ,	21078
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ure Andrew	ES.		/	/ /	•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician STANLEY 1/7/2007 7:15 PM MELVIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GLENDALE PRINCE GEORGE'S 8104 SPRINGFIELD ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 12/1/1935 WASHINGTON, DC 71 Director 220-30-0220 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 TYes 2 X No Director WASHINGTON D.C. 10f. Zip Code 10α. Citizen of What Country? 10e. Street and Number 20020 2820 31st. S.E. #717A U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:WHITE ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE MUSICIAN 12 f Health and Mental Hyginitem 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MABEL STANLEY JOSEPH STANLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2820 31st. S.E. #717A WASHINGTON, D.C. 20020 RETTY STANLEY - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o XXBurial 2 Cremation 3 Removal from State 1/18/2007 LINCOLN CEMETERY BRENTWOOD, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 21. Signature of Funeral Service Licens 3401 BLADENSBURG ROAD., BRENTWOOD, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy ŏ in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) I □Yes 2 □ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 X No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specification) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No ٤ this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number signed (Month, Day, Year) 29b. Signature and title of certifier Geath (Item 23a) (Type, Print)
5001 Silver Will Rd. # 101 Suitland Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LSGGCS M.D. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - State Registrar	State of M	arylan				lealth and Death	Mental H	ygien		7	02318
	Physici	an	Decedent's Name (First, Middle, Last) Olive Rebecca SHUT	ՐΤ <u>Ι </u> . Ե ԱՐՋΤΙ	4					2. Date of I	C		ear	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give si Reeder's Memorial	treet and number,			4b. City,		Location of Dea	JAMUA uth		7, 200 c. County of Was	Death	11:10P.M
	Funeral Director		427-62-4374	M 2 ⊠ F	ge (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hr Hours Mir	8. Date of E (Month, L Aug.	$\overset{\text{Birth}}{18},$	⁷⁾ 1919	Birthpl Coun Mis	ace (State or Foreign try) Sissippi
	death with the Maryland ms 23a or 28a-f show Entitlet be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Washir	ngton	10c. Cit	ty, Town or Lo		m					10	0d. Inside City Limits 1 ☐ Yes 2 No
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BECCA 0036	5 £ 5	d by Funeral		2, Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No					Specify Yes or I rto Rican, etc.)	1	14. Race - Black, 1 Specify:	White, 6	
LITUE WOISTH REDECTIONS Baltimore, Maryland 21215-0036	d within 72 h giene. er then "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2		5+)	16a. Deced (Give life. L teacl	kind of wo DO NOT u.	al Occupa rk done d se retired	ation furing most of w)	orking	16b.	Kind of Busin		·
/land	uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Thaddeus William	Scott						ame (First, Middices Luci			ngha	am
WOISTH e, Marylar	d 2 sho th and ! 7 ie mu treuma		19a. Informant's Name/Relationship (Type Becky Leverett –		_		_			Rural Route Num Hagerst				
$\mathcal{LE}_{\mathcal{U}}$	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itsm 27 is marked other then any Injury or other freumatic event, II a Mac. 2016.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. F	Place of Disposemetery, cren	sition (Nar	ne of ther plac	1	Date	20c.	Location - Cit	y or To	
NKTTLE Baltimor	permit. I Departm Importa eny Injui		21. Signature of Funeral Service Licenser Frud L. V.	/					s of Facility	MINNIO	CH FU	JNERAL	HOM	ΙE
● ∑	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one timmediate Cause (Final disease or condition resulting in death)	ations that cause e cause on each I Due to (or as	ALY	herme				ac or respiratory	arrest,			Approximate the three th
8760,	cate be executed by scien end the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
P.O. Box 687	certifi nding	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	I death 3	Ectopic pr				-	23d. Date o		ry Day Year
	requires thet the death een signed by the atter hould be detached for u	ρ	Part II. Other significant conditions cont			ulting in the ur		ause give	en in Part I.	1				e cause of death?
al Reco	e law has b	Completed								per	is an lopsy formed?	deat	th?	sy findings available apletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: Th within 24 hours elter death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ion; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Ho 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	espital: 1 ☐ Inpati 28a. Date of Inju (Month, Da		ER/Outpatient 28b. Time of Injury	2	8c. Injury Work	4 Nursing	Home 5 Re	sidence		Specify)
Divisio	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Ptace of In building, e	jury - At ho tc. <i>(Specif</i>	ome, farm, stre	M eet, factory		/es 2 □ No	28f. Location City or T	(Street a	and Number o	or Rural	Route Number,
	he Hoepital in 24 hours the Funeral pletely filled	edical	29a. Certifier 1 G-Certifying Physic (Check only one) 2 Medical Examination)	cian: To the best er: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred restigation	at the tim	e, date and place pinion, death occ	e, and due to the urred at the time	e cause(e, date a	s) and manne nd place, and	or as sta due to	the cause(s)
	To the within 2 To the complete	×	29b. Signature and title of certifier	0				License	number			ate signed (A		
S	H-10		30. Name and address of person who com DR. VASANT DATTA, 3	npleted cause of d 340 MILL	STRE	ET, HAC	Print) GERST	own,	MARYLAI	ND 21740) 30	01-739-	-710	00
	Sta Registi		31. Date filed (Month, Day, Year) JAN 18 200	32. Begiste	_	iture	ر ابور							

DHMH 17 Rev 1/2001

		For	State of Man		rtment of Heal		ental Hygie	ene	00010
		1 - State Registrar		Cer	tificate of Dea	ath		J. Ng.	02319
Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	Helen Louise 4a. Facility Name (If not institution, give		Staley	4b. City. Town, or Loca		January 1	4c. County of Death	7:47AM M
Examin	er	, ,	,		_				
Funeral		7526 Mt. Laurel F 5. Social Security Number 6. Sec		n yrs. last birthday)		Inder 24 Hrs.	8. Date of Birth	Washing 9. Birthp	lace (State or Foreign
Director		220-54-3681] M 2□ X F	74 Yrs.	Months Days Ho	ours Min.	(Month, Day,) March 30		nsylvania
p		Usual Residence of Decedent							
aryla:	٦	PA Frank		Oc. City, Town or Lo	ynesboro			'	0d. fnside City Limits 17 Yes 2 No
he M	Director	10e, Street and Number	CI III	wa	10f. Zip Code		100	Citizen of What Cour	A
with	급	11948 Northwood	lov Drivo				100		my:
ne 23	Funerai		12. Was Decedent Eve	er in U.S. 13. V	17268 Vas Decedent of Hispani Yas, specify Cuban, Me	ic Origin? (Spe	ocify Yes or No-	U.S.A.	
or Iter	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No				Rican, etc.)	Black, White,	
rali, o	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐Yes 2ÃDNo Spe	ecity:		Specify: wh	ite
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within then then then then then then then the	E G	Elementary/Secondary (0-12)	College (1-4or 5+))1 D-	
int, it		17. Father's Name (First, Middle, Last)		по	memaker	Mother's Name	(First, Middle, Ma	ersonal Re	sidence
d be entat	To Be	Edgar R. Overca	ach			Dlane	ha Cmaua	se Overcash	
I all y late to the within 72 hours after deeth with the Maryland 2 should be filed within 72 hours after deeth with the Maryland and Mentle than "natural", or lisme 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	-	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street and N				Code)
ite, intally idailed KIKI Orocood 1 and 2 should be filed within 72 hours after deeth with the Marylan 1 Healith and Mental Hygiene 1 Healith and Mental Hygiene 1 the marked other than "natural", or theme 28a or 28a-f show other traumatic event, the Medical Examinar must be notified at		Deborah McMillen	(daughter)	752	6 Mt. Laure	1 Rd. F	constore	Maryland	21713
of He		20a. Method of Disposition 1 ← Burial 2 ☐ Cremation 3 ☐ F	1	20b. Place of Dispo-	sition (Name of natory or other place)	D	ate 20	c. Location - City or To	wn, State
mit. Pages partment of I portant: If its y injury or o		4 Donation 5 Other (Specify)			n Mem Park	1-19	9-2007	Hagerstown	Maryland
Dealtimore, Minore, Minore, Minore, Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra		21. Signature of Funeral Service Licens	90	22	. Name and Address of F	Facility Dou	ıglas A.	Fiery Fuen	ral Home
405 e d		23a. Part1. Enter the disease, of compl	tery	1	3 <mark>31 Eastern</mark>	Blvd.	N. Hager	stown Mary	land 21742
	, (shock, or heart failure. List only or	ne cause on each line.	e death. De not ente	er the mode of dying, suc	ch as cardiac o	r respiratory arres	τ,	Interval Between Onset and Death
Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	OVCF,		morre			/	omorts
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ettenc for us	ian	in the past 12 menths?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ny Day Year
the d	Physician/Me	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	9□ Unknown	io di dolli i	Cities (specify)				
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wrequires to been signer should be	ed b	lover ory ar.	tery Du	iense			1 ☐ Yes	2 12 No 3 □ Prob	ably 4 □Unknown
aw re	piet	,					24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
The The ate has page	Completed						performe	death?	
clan: clan: ertific sctor,	Be (25. Was case referred to medical examiner?			T -	Pface of Death	(Check only one)		
this o	2	10 165 20160	lospital:	2 ER/Outpatien				ce 6 Other (Specific	()
After funer	ion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	(ear) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		28d. Describe how	injury occurred	
Attending at death. ector: Afte by the fune	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, stre			28f. Location (Stre	et and Number or Rura	l Route Number,
after dinb	Certification:	4 Homicide	building, etc. (Specify)	,,		City or Town,	State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of n	ny knowledge, death	occurred at the time, da	ite and place, a	and due to the cau	se(s) and manner as si	ated.
the H in 24 the F	ledicai	one)	and manner stated	d.					
To To con	Σ	29b. Signature and title of certifier	11 1/	110	29c. License num			d. Date signed (Month,	Uay, Year)
		Vuelle	for	JUP	D23(Print) 10 11 lease	125	1/	DHURRY //	100
5H-10		30. Name and address of person who co	implater cause of deat	th (ftem 23a) (Type,)	rint)	1 1/2 -	17 Por St	torusta	MI 7 -
Sta	te	31. Date filed (Month, Day, Year)	32. Hegistrar's		1 11 cource	1 mile	10.11	c) os wer	1112. /1/4/8
Registr		JAN 18 20	101 Lesera	1 13. Ago	was				

			<u> </u>		-	Certificate		Death		Reg. No.	07	02321
	Physic	ian	Decedent's Name (First, Middle, La						2. Date of De Month	Day	Year	3. Time of Death
-	/Medi	cal	PRESTON	SCO					Januar		2007	5:15 PM
Į.	Examir	ner	4a. Facility Name (If not institution, give		,			4b. City, Town, or Lo		h 4c. County		
			McCready Memorial 5. Social Security Number 6.5		no (In um lagt high	day) If Under	Vear	Crisfi If Under 24 Hrs.		dh	Somer	
	Funeral Director			1 M 2 □ F	ge (In yrs. last birth 87 Y	Months		Hours Min	8. Date of Bi (Month, Da April	o, 1919	9. Birthol Count Maryl	lace (State or Foreign try) Land
	/land		10a. State 10b. County		10c. City, Town	or Location					10	0d. Inside City Limits
	Man	ģ	Maryland Some	rset			Cri	sfield				1∐XYes 2□No
	h with the 23a or 28 at be not	Funeral Director	10e. Street and Number 204 Laird Avenue	9		10f. Zip (Code	21817		10g. Citizen of USA		try?
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	Everinu,s. No World War II	13. Was Decede If Yes, speci 1 ☐ Yes 2		dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, e	
5-6	72 h	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. [ecedent's Usual Give kind of work	Occup done	pation during most of working)	ing	16b. Kind of B	usiness/Ind	ustry
121	within	E	Elementary/Secondary (0-12)	College (1-4or	5+)				-			
2	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)		C	wne	18. Mother's Name	/Eiret Middle			Service
an	d be intral	Be	Marvin Scott	•				Helen St	•	, maden camar	110)	
Z	2 should be filed withir and Mental Hygiene. s marked other than aumatic event, the Ma	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. I	Aailing Address	Street	and Number or Rura		er City or Town	State Zin	Code)
E	id 2 sho Ith and 17 is me traum											
ē,	Health Health tem 27		Preston Scott, Jr 20a. Method of Disposition	(Son)	20b. Place of D	DI ALON Disposition (Name crematory or oth	chu of	ırch Road	Date	20c. Location		
Baltimore,	Peges nent of h int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	I amount a service and				/3 4 /07			
=	permit, Pege Department of Important: If any injury or once.		21. Signature of Funeral Service Lice		Sun yr	idge Mem 22. Name and		al Park 1	/14/07	Crisfie	eld, M	laryland
Ba	Depariment of the policy of th		Why Kell	Biles	THE			Sons Fun	eral H	ome		
			Mary Beth Bra		tt			n Street				
			23a. Part1. Enfer the disease, or com shock, or heart failure. List only	plications that cause one cause on each l	d the death. Do no ne.	t enter the mode	of dyir	ng, such as cardiac o	r respiratory a	rrest,	-	Approximate Interval Between Onset and Death
1.	Physician /Medical		Immediate Cause (Final			Λ	_				1	Onset and Death
	Examiner		disease or condition resulting in death)	a		ASCV						
		70			Due to (or as a co	nsequence of):					1	
	ted 1sit	n lu	•	b								
	tificate be executed ig physician and es the burlel-transit	хаг	Sequentially list conditions, if any, leading to him. Just cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a co	nsequence of):						
68760,	be e iician burk	<u>e</u>	cause. Enter Underlying Cause (Disease or injury	C								
587	icate phys	agic a	resulting in death) Last		Due to (or as a cor	nsequence of):						
		Physician/Medical Examiner	L	d								
Box	eath atter I for u	ciar					-,-		1			
P.O.	the d y the	Jysi	Part II. Other significant conditions of		_		ıse giv	en in Part I.				the cause of death?
	The law requires that the death cert ate has been signed by the attendin page 2 should be deteched for use	by Pi	(JI B	LEEDIN	6			1	Yes 2 No	3 🗌 Prob	ably 4 ☐ U∩known
Records,	ulres n sigr								24a. Was	an autopsy	24b. Wer	re autopsy findings
Ö	v require been sig	lete							perfo	rmed?	com	ilable prior to apletion of cause leath?
Re	ne law e has ige 2	Completed								e levi.		
G	ysicien: The la is certificate ha director, page		25. Was case referred to medical					00 81	10		1	Yes 2□No
of Vital	sicie certi irect	o Be	examiner? 1 ☐ Yes 2★ No	Hospital:	ent 2 ER/Outp	ations OF DOS	Oth	26. Place of Death er:			(0 11	
	Phys rthis eral d	: To	27. Manner of Death	28a. Date of Inju			c. Injur	4 Li Nursing non		dence 6 ∐Oth how injury occur	1 1 27	1
o	ding th. : Afte	tior	Natural 5 Pending investigation		y Year) Inju	ıry M		k? Yes 2 □ No		, ,		
Division	or Attending Physicien: after death. Director: After this certifica in by the funeral director,	fica	3 ☐ Suicide 6 ☐ Could not b		ury - At home, farm c. (Specify)	, street, factory,			8f. Location (Street and Numb	er or Rural	Route Number,
$\frac{1}{2}$	after Dire	Certification:	4 ☐ Homicide determined	building, ef	c. (Specify)				City or To			
	spita nours nerel		29a. Certifier Certifying Ph	yslcian: To the best	of my knowledge, o	leath occurred at	the tim	ne, date and place, a	ind due to the	cause(s) and ma	anner as sta	ited.
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner st	f examination and/	or investigation, in	n my o	pinion, death occurre	ed at the time,	date and place,	and due to t	the cause(s)
	Fo th withir Fo th	M	29b. Signature and title of certifier			29c.	icens	e number		29d. Date signe	d (Month, D	lay, Year)
				10	+ en		0 4	18098		1/12	1260	7
			30. Name and address of person who	completed cause of c	leath (Item 23a) (Ty			· ·			1	
			Vijay Karumbuna				hwa	v - Crisf	ield. N	Marvland	2181	7
	Sta	te	31 Date filed (Month Day Year)	32 Registe	ar's Signature				,	1		
	Registr		JAN 1 6	2007	we k	Grant						
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			For State Registrar		State of M	laryla				lealth a D <i>eath</i>		1ental	Hygie _{Reg.}	201	7	02322
	Physic	-	1. Decedent's Name (First, I	Aiddle, Las	t)							2. Date of		Day	Year	3. Time of Death
	/Medi		Evelyn Loret	ta Sa	nner							Janu		18, 20	007	2:25 A. M
	Examir	ner	4a. Facility Name (If not inst.)				Location	of Death			4c. County		
			Goodwill Men 5. Social Security Number	non1t		an (In um	. last birthday)		ntsv:	IIIe	24 Hrs	0 Data a	4 Dieth		rett	10
	Funeral Director		216-74-8268 Usual Residence of Decede	1	□ M aRCe I	98 	Yrs.		Days	Hours	Min.	June	f Birth I, Day, Ye 20,	1908	9. Birthp Coun Penr	lace (State or Foreign htry) nsylvania
	land ow		10a. State 10b. Co			10c. C	ity, Town or Lo	ocation							1	Od. Inside City Limits
	the Marylan 28a-f show	to	MD Ga	rrett		Δα	cident									1 ∑X es 2 ☐ No
	ith the	irec	10e. Street and Number			110	CIGCIIC	10f. Zi	p Code			-	10g.	Citizen of V	Vhat Coun	itry?
	th wit	a D	101 Town Vie	w Dri	ve				21520)				USA		
21215-0036	iiit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. Cortant: If itam 27 is marked other than "natural", or itams 23e or 28e-f show injury or other traumetic event. The Medical Examinar must be notified at a	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Divo		12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Dece If Yes, spe 1 Yes		spanic Ori n, Mexicar Specify:	igin? (Spe n, Puerto	ecify Yes o Rican, etc	r No-	Blac	e - Americ k, White, whi	etc.
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215	within 7 ene. than "r hs wed	Completed	(Specify only find Elementary/Secondary (0-		College (1-4or	5+)	lite.	DO NOT L	onk done d ise retired,	luring mos)	t of worki	ing				
	2 should be filed within and Mental Hygiene. is markad othar than aumatic avant, ht. M	Sol	_12				Homen	naker		_				Own I		
Maryland	be fill tal Hid oth avan	Be	17. Father's Name (First, Mic	ddie, Last)									ddle, Maid	den Sumam	θ)	
yla	ould h	မ	Watson Guard				_				dna (
Mar	12 sho h and l 7 is ma		19a. Informant's Name/Rela											ty or Town,		Code)
	of Health itam 27 i		Clyde C. Sani 20a. Method of Disposition	ner,	Jr./son	20h	J824 Place of Dispo			TTE		Frie		ille,		21531
Baltimore,	Pages nent of int: If its iry or o		1 \$ Burial 2 ☐ Crema	tion 3 🗆	Removal from State	.	cemetery, crei	natory or o	other place						•	wn, State
臣	permit. Pag Department Important: any injury c		' 4 ☐ Donation 5 ☐ Oth 21. Signative of Fire eral Se			AC			_	,				dison		
Ba	permit. Pages Department of Important: If i any injury or once.		1 8 1	bur			Ne	wman	Fune	eral I	Homes	s, P.	A., 1	PO Box	275	
1/2	18.3		23a. art1. Exter the diseas	e or comp	lications that cause	d the dea	ith. Do not ent	9 Mi. er the mod	ller de of dying	St.,	Crar cardiac o	ntevi or respirato	lle,	MD 2	21536	Approximate
	Physician		Immediate Cause (Final	List only	one cause on each I	9-	const	i						n	. 1	Interval Between Onset and Death
	/Medical	8	disease or condition resulting in death)	-	a	a conse	quence of):	2504	Va	5Cli	kar	ac	ude	w		IWEEK
	Examiner				· huo	ext	Dude	g-								ingers
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68760,	ficate be executed physician and s the burial-transit	edical		•	d											
O. Box 6	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	t	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fet	al death 3	Ectopic p						23d. Date Mon	e of deliver	ry Day Year
σ.	that the de ed by the detached		Part II. Other significant co	ditions or	entributing to death t	out not re-	sulting in the	nderking	Sallee Citic	n in Part I		220 5	id tobaca	n use conta	ibute to #	e cause of death?
Records,	uires tha I signed I Id be det	d by	,		4 disease			idonying c	auso givo	ii iii Faiti.				* I		ably 4 Unknown
200	w requir been si should	Completed			/ Joyana							242 1	Vas an	245 14	lasa sutas	ens finalismo esseitable
Re	sician: The law s certificate has b irector, page 2 s	ш				_						а	utopsy erformed	. D	rior to com eath?	sy findings available apletion of cause of
_	ificate or, pa		25. Was case referred to me	dical						00 81	-1511	1 □ Y€	s 2	Q O 1	☐ Yes	2 No
>	Physician: this certificatal director,	o Be	examiner?		Hospitai: 1 ☐ Inpatie	ent 2	ER/Outpatien	t 3 🗆 DC	Othe	r . /		(Check or		6 TO#-	. (0	1
			27. Manner of Death		28a. Date of Inju	ıry	28b. Time of		28c. Injury Work					6 Othe	, , , ,)
ion	Attanding F death. ctor: After y the tuners	atio	1 Natural 5 ☐ Pe	inding restigation	(Month, Da	iy rear)	Injury	М		? 'es 2 □ 1	No					
Division	or / or / or / or or or or or or or or or or or or or o	Certification:		ould not be termined	28e. Place of In building, el	jury - At h tc. <i>(Speci</i>	nome, farm, stre	eet, factory	y, office		2	28f. Locatio City or	n (Street Town, St	and Numbe ate)	r or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one)	ifying Phy ical Exam	rsician: To the best iner: On the basis o and manner st	f examina	owledge, death ation and/or inv	occurred restigation	at the time , in my op	e, date and inion, deat	d place, a th occurre	and due to ed at the tir	the cause ne, date a	(s) and mar and place, a	ner as sta nd due to	ited. the cause(s)
	To the within 2 To tha complex	Med	29b. Signary and title of ce	rtifier	4	/		290	c. License	number	_		29d. l	Date signed	(Month, D	Pay, Year)
	r s F ä		Mars	2/1	a K	in	w	\	12	6607	1					
			30. Name and address of ge	son who c	ompleted cause of a	death (Iter	m 23a) (Type	Print)	1) 4	2026			· ·	-17	20	
1	3		margant	ake	USPR I	id	130	19 an	aut	1 hi	serie	dy	011	klan.	1. 2	07 1d 21550
• 0	Sta Registr		31. Date filed (Month, Day,)	ear)	32. Registr	ar's Sign	ature		00	- (- 00	10-10	11	

			For State		State	of Mar	yland /		rtment tificate			and Me	ental Hyg	0.7		000	3 3 3
	1		Registrar 1. Decedent's Name (Fig. 1)	iret Middle I	net)			Cer	inicate	9 01 1	Deam		2. Date of Dea	eg. No.	JUI	3. Time of	Doath Doath
9	Physicia /Medic		i. Decedent's Name (7)	Rosi	•	в.		Sim	mons				Month 01	Pay	0^{Year}	1640	М
)	Examin		4a. Facility Name (If no			umber)					Location of	of Death			nty of Death		
	gia.	di Samu	WMHS Brad 5. Social Security Numb		ampus Sex	7 400	(In yrs. last	hirthday	If Under		land	24 Hrs 1	8. Date of Birth		legan		- F
í.	Funeral Director		422-26-084		1 □ M 2 🙀 F	80	,	Yrs.	Months	Days	Hours	Min.	Month, Day	, Year)	Соц	place (State on Intry) bama	ir Foreign
	pu ,		Usual Residence of De	cedent			10c. City, To	aum or Loc	ation				ocpe re	1 100			Av. I for the
	faryla f shov ed at	ō		b.County Garrett				tsvi.								10d. Inside Ci 1 ☐ Yes	
	the N 28a-i notifi	Director	10e. Street and Numbe						10f. Zip	Code			<u> </u>	Og. Citizen	of What Cou	ntry?	
	th with 23a ol 1st be		260 Kil	ldeer L	ane					21	.536			1	USA		
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 ▼ Widowed 4 □		12. Was De Armed F 1 Yes If Yes, O Year or	Forces? 5 2 ⊠ No Give			Vas Decede Yes, spec □Yes 2		ispanic Ori an, Mexicar Specify:	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		Race - Ameri Black, White, ecify:	etc.	
0	2 hour atural cal Ex	ed b	15.	Decedent's E	ducation		16	6a. Deced	ent's Usua	l Occup	ation		1	16b. Kind o	f Business/Ir	whit ndustry	.e
215	thin 72 e. an "na Media	Completed	(Specify of Elementary/Seconda		ade completed College	(1-4or 5+)		(Give I life. E	kind of worl OO NOT use	k done c e retired	during mos d)	t of working	7			,	
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ary	ages 1 and 2 should b nt of Health and Ment : If item 27 is marked r or other traumatic e	₽ L	19a. Informant's Name	/Relationship	(Type. Print)		1	9b. Mailin	g Address	(Street a	and Numbe	er or Rural	Route Numbe	r, City or To	wn, State, Zi	c Code)	
	1 and 2 Health a tem 27 is	- 55	Carol I		y/daugh	nter					Rd.,		ndsvill	e, MD	2153	1	
altimore,	Pages 1 nent of He int: If iten		20a. Method of Disposit 1 ☑ Burial 2 ☐ Ci		∃Removal fror	n State		etery, crem	natory or ot	ther plac	· i	Da			on - City or T	* '	
<u>=</u>	g 5 m c		4 ☐ Donation 5 ☐ 21. Signature of Funera				Holly		.1 Men		,		, 2007	Balt	imore	, MD	
Ba	permit. Departr Importa any Inji		10/2	X	7000	a. /		Nε	wman	Fun	eral	Homes	s, P.A.	, PO 1			
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	/Medical Examiner		resulting in death)		Due to	o (or as a	consequenc	ce of):								,	
É	- - 1	ler	Sequentially list condition cause. Enter Underlyin Cause (Disease or injuries)	ons,	b. Due to	o (or as a	consequenc	ce of							- 1		
	cuted nd ransit	Examiner	that initiated events		c												
90,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	- 1	Due to	o (or as a o	consequenc	ce of):									
28760	physical phy	dical			▲d												
ROX	leath certific attending p	III/M	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, o		pregnancy	ath o∏	Ectopic pre	anana				23d.	Date of deliv	ery	
O. B	e deat the attr	Physician/Me	in the past 12 mor			gnant at tir	me of death		Other (spe						Month	Day	/ear
<u>. </u>	that the de ed by the detached		9 ☐ Unknown Part II. Other significar	nt conditions	contributing to	death but	not resulting	g in the un	derlving ca	use aive	en in Part I.		23e. Did to	bacco use c	ontribute to t	he cause of d	eath?
Hecords,	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	d by												es 2∏ No		bably 4 🗷	
ဂ္ဂ	law require as been si	Completed											24a. Was a		b. Were auto	ppsy findings	available
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Vital	certific sertific	Be (25. Was case referred examiner?	to medical	Linemital:					Tau		of Death (Check only or	•			
o	Physical this caral dire	٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death			Inpatient e of Injury		Outpatient o. Time of	3 DO/		4 L INU		e 5 Resid			fy)	
0	nding th. :: After	tion	_	Pending investigatio	(Mo	nth, Day Y		Injury	м	Bc. Injury Work 1 □ `	k? Yes 2 ∐ l	1	d. Describe in	ow injuly oci	Surrec		
DIVISION	r Atter er dea irector	Certification:		Could not be determined	28e. Plac	ce of injury ding, etc.	- At home, (Specify)	farm, stre	et, factory,	office		28	If. Location (S City or Town		mber or Run	al Route Num	ber,
ב	oital o urs aft eral Di																
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)	Certifying Pi Medical Exa	hysician: To th miner: On the and ma	basis of e nner state	xamination d.	and/or inv	estigation,	in my o	pinion, dea	th occurre	d at the time, o	late and plac	ce, and due t	o the cause(s	·
	with Con	M	29b. Signature and title	of certifier	1	N			29c.	License	number	7)	enlar	9d. Date sig	ned (Month,	Day, Year)	
		0	30. Name and address	of person who	completed car	use of dea	th (Item 23a	a) (Type, F	Print)	ノス	33.	1 1		-			
شي		2	Gamar		an	625	Ke,	nt c	aven	140	Cu	mbo	enlar	el, 1	MARY	land	
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						- And Charle		900	San San San San San San San San San San								

		For State	State	of Marylan	-	artment of F		ind M		iene	007	02324		
*		Registrar 1. Decedent's Name (First, Middle,	Last)				Dodan		2. Date of Deat			3. Time of Death		
Physicia	_	BETTY		SM	ITH				Month	Day 1 1	Year 2007	5:25 A M		
/Medic Examin	100	4a. Facility Name (If not institution,	give street and nu			4b. City, Town, o	or Location of	f Death	JANUARY		∠UU / ty of Death	J.25 A		
LXaiiiii		MEMORIAL HOSPITA	ΔT			CUMBE	RLAND			ALLEG	SANY			
Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs.	8. Date of Birth (Month, Day,	Voar)	9. Birth	place (State or Foreign		
Director		215-26-7692	1□M 2[XF	79	Yrs.	MOTHITS Days	Hours	IVIII).		28, 1927	Cou	place (State or Foreign ntry) Maryland		
pu ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Limits		
anyla shov	5		4.11	100.01	y, rowiror Lo	cation						1 ☐ Yes 2 ☐ No		
he M 28a-f ottfic	Director	Maryland 10e. Street and Number	Allegany			10f. Zip Code	Lonac	oning	4	0g. Citizen o	E Mihat Cau			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Ö		Duidee Stud	. a t		Tot. Zip Code	215	20		og. Olizen o		S.A.		
eath ns 23 must	Funeral	11. Marital Status	Bridge Stre	cedent Ever in U.	.S. 13. \	Vas Decedent of H			cify Yes or No-	14. Ra	ace - Ameri			
r Iten	표	1 Never Married 2 Marrie	Armed F ed 1 ☐ Yes	2 No		Vas Decedent of H f Yes, specify Cub		, Puèrto F	Rican, etc.)	BI	ack, White,	etc.		
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be fill d oth even	Be	17. Father's Name (First, Middle, L	.ast)				18. Mother	r's Name	(First, Middle, I	Maiden Surna	ime)			
ould Men narke	ပ္			ford Smith	T			_		Fannie M				
l 2 sh n and ris m		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street	and Numbe	r or Rural	Route Number	, City or Tow	n, State, Zij	o Code)		
1 and Health em 27 ther tr	1	Earl S 20a. Method of Disposition	mith - Son	20b. F	Place of Dispo	605 sition (Name of	<u>Dunkirl</u>		l, Baltimor	e, Maryl 20c. Location				
Pages nent of h int: If ite iry or of		1 ⊠Burial 2 ☐ Cremation			emetery, crer	natory or other pla	ce)		January 15,	200. Localion	olly of t	JWII, State		
	-	4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L				urg Memori Name and Addre			2007	F1	rostburg	, Maryland		
permit. Departr Imports any inja		21. Signature of Furieral Service L	K			Hame and Addic			IcKenzie F	uneral H	ome P.	٩.		
		23a. Part . Enter the disease, or	polications that	caused the deat	h. Do not ent	er the mode of dvi	R East	Main S	treet Lon	aconing,	MD 21	539 proximate		
		shock, or heart failure. List of immediate Cause (Final	only one cause on	each line.		,	0.					Onset and Death		
Physician /Medical		disease or condition resulting in death)	a. SEPS	IS (or as a conseq								l WEEK		
Examiner					,	TON						1 WEEK		
	ē	Sequentially list conditions, if any, leading to immediate		STINAL (or as a conseq		LIUN						T WELL		
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MESE	NTERIC V	VASCULA	AR OCCLUS	SION					1 WEEK		
be executed ician and burial-transit		resulting in death) Last		(or as a conseq										
cate be executed by sician and the burial-transit	dical		d											
ng ph as th	Med	IF FEMALE:												
eath certific attending p	an/l	23b. Was decedent pregnant		itcome pf pregna birth 2 ☐ Feta		Ectopic pregnanc	у				ate of deliv	*		
e dea he at led fo	sici	in the past 12 months? 1 ☐ Yes 2 🗷 No	4□Preg 9□Unki	nant at time of d	eath 5	Other (specify) _				N	fonth	Day Year		
at the	Physician/Me	9 ☐ Unknown Part II. Other significant condition	no contributing to	loath but not roo	ulting in the ur	dorlying course gir	on in Bort I		220 Did tob	2000 1100 00	ntributo to t	he cause of death?		
To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	þ	ACUTE RENAL FAII					en in Faiti.					bably 4 Unknown		
requ bould	Completed	HISTORY OF ABDOM					J							
e faw has t	nple.	HISTORY OF ABDUR	TINAL AUR	TIC ANE	UKISH .	WESTOI TO	·		24a. Was ar	V	prior to co	opsy findings available impletion of cause of		
iclan: The lav certificate has ector, page 2									1□ Yes 2	ned? 2 No	death? 1 ☐ Yes	2□ No		
siciar certif	Be	25. Was case referred to medical examiner?	Hospital:			t 2000A Oth	or.		(Check only on					
Phys r this ral di	٠ <u>۲</u>	1 ☐ Yes 2 No 27. Manper of Death	X	Inpatient 2 of Injury	ER/Outpatien 28b. Time of	1 3 DOA	4 LI Nui		ne 5 Reside			fy)		
ding h. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investig	,	nth, Day Year)	Injury	28c. Inju Woi M 1 □	rk? Yes 2∐N			,,				
Atter deal	fica	3 Suicide 6 Could n	ot be 28e. Plac	e of injury - At ho	ome, farm, str	eet, factory, office		2	8f. Location (St.	reet and Nun	nber or Run	al Route Number,		
al or safter	Certification:	4 ☐ Homicide determin	build	ding, etc. (Specif	у)				City or Towr	n, State)				
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.			Physician: To th											
n 24 he Ft he Ft	Medical	(Check only 2 Medical E	xaminer: On the and ma	nner stated.	ition and/or in	vestigation, in my	opinion, dea	th occurre	ed at the time, d	ate and place	e, and due t	o the cause(s)		
To t To t	Σ	29b. Signature and title of certifier	1//	.11		29c. Licens	se number		29	9d. Date sign				
) //	HIM	11100		D 19	318			Jar	1/1	2007		
	,	30. Name and address of person v	vho completed cau	ise of death (Item	23a) (Type,	Print)		—— П	21502					
	8	DR. N.A. RANJIT				COMBEKL	minu, P	ту	21302					
Sta		31. Date filed (Month, Day, Year) JAN 1	0 000-	Registrar's Signa		ST and								
Registr	ar	2,111	0 2001	La Realis	OF SHE	BARGAS								

			1 ⊷ For State Registrar			nd / Dep		t of H	ealth a		lental Hy		200	07	02	325
148	Physic	ian	1. Decedent's Name (First, Middle, Nora N. T	Last) erzian							Date of De. Month	Da	χ .	Year	3. Time of	
1	/Medi	cal	4a. Facility Name (If not institution,	give street and gumi	her)		4h City	Town or	Location of	of Dogsth	Januar			2007 y of Death	3:05	РМ
-	Exami	ier	Trudie's Senior						pring	n Death				gomer		
-	Funeral Director		<u> </u>			. last birthday) Yrs.		1 Year	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da 10/17/1	th			place (State on ntry)	or Foreign
	yland now		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation								10d. Inside C	ity Limits
	e Mar	Director	DC		Wa	shingto	on								¹ ∏ Yes	2 🗌 No
	with th	Dire	10e. Street and Number				10f. Zip							What Cou	•	-
	eath v	Funerai	2848 27th stree	t N.W.	ent Ever in I	19 12	Was Door	200		-:-2 /5	and the Man and Man			Sta	tes	
920	n 72 hours after death with the Maryland "natural", or itams 23a or 28a-1 show culcal Examilinar must be notified at	þ	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Ford	es? ∭No		If Yes, spec			gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		B!a	ck, White fy: Whi	etc.	
215-0	c * 3	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ition furing most	of worki	ng	16b. K	nd of B	Business/Ir	dustry	
121	TI 'Co = ***		12			На	airdr	essei					iva			
Maryland 21215-0036	should be filed and Mental Hyg marked othe matic event,	To Be	17. Father's Name (First, Middle, L Unknown						Unkı	nown	(First, Middle,					
e, Ma	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked to any injury or other traumatic evonce.		19a. Informant's Name/Relationsh Edward Dombalag 20a. Method of Disposition			3712	Clair	cton	Driv	e 1	Bowie,	MD 2	2072	1		
Baltimore,	Pages Iment of h tant: If its jury or of		1 ★ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 □Removal from St ecify)		Place of Dispo cemetery, crer rt Lino	coln (Cemet	ery	1/16		Brer	itwo	od, l		
Bal	permit Depar Impor any in		21. Signature of Funeral Service	ey _il-		34	401 B1	Lader	sbur	g Ro		entw			Home 20722	
* **	Physician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	aAdva	n line.	lzheim		e of dying	, such as o	cardiac o	r respiratory ar	rest,			Approximate Interval Bette Onset and I	ween Death
o'	*	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq											
Division of Vital Records, P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed redeath. The addition of the certificate has been signed by the attending physician and softer this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Feta	ll death 3 □	Ectopic pro							te of delive	-	'ear
P.O.	at the de f by the a stached	Physic	1 ☐ Yes 2♥ No 9 ☐ Unknown	9□ Unknow			Other (spe									001
ords,	w requires the been signed should be d		Part II. Other significant condition	s contributing to deat	h but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to	7	,		ne cause of do ably 4 □U	
al Rec	sician: The law i certificate has bi irector, page 2 sh	Completed									24a. Was a autop: perfor 1 ☐ Yes			Were auto prior to co death? 1 Yes	psy findings a npletion of ca 2 No	available ause of
Ĕ	ysician: Is certific director,	Be.	25. Was case referred to medical examiner?	Hospital:				Other	_		(Check only or					
ion of	nding Physith.: After this funeral di	ation: To	1 Yes XXNo 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month,		28b. Time of Injury		Bc. Injury Work	420 IAIII	2	ne 5 Residente 18d. Describe h				()	
Divis	tal or Attendes is after death all Director:	Certification:	3 Suicide 6 Could no determin	ed 28e. Place of	Injury - At he etc. (Specif	ome, farm, stre	et, factory,	office		2	8f. Location (S City or Town	treet and n, State)	d Numb	er or Rura	I Route Num t	ber,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medicai (29a. Certifier 1 Certifying (Check only one)	Physician: To the be taminer: On the basi and manner	o ul oxamina	wledge, death tion and/or inv	occurred a restigation,	it the time in my opi	e, date and nion, death	place, a	nd due to the c d at the time, d	ause(s) late and	and ma	inner as si and due to	ated. the cause(s)	
	To the complete	Σ	29b. Signature and title of certifier	h Gell	100	7+	29c.	License D	number 2230	9	2	29d. Date		d (Month, 2/200	Day, Year)	
2	(10)		30. Name and address of person when Phillip W.	Poth, M.I).		8712	2 May	wood	Ave	. Sil	ver	Spr	ing,	MD 209	910
	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 1 6 200	7 Sacces	strar's Signa	ture pour	U									

DHMH 17 Rev 1/2001

			forAmend Item #32		aryland		ment of Ficate of			giene	0.7	02326
			Decedent's Name (First, Middle, La						2. Date of Dea	ith		3. Time of Death
×	Physici		Michael Thomas	Tosadori					January	/ 15	2007	7:00 A M
	/Medi Examir		4a. Facility Name (If not institution, give			41	c. City, Town, o	r Location of Dea		1	ty of Death	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		. 200	27 South Locust	St. Apt.	1		Ha	gerstown		V	Vashin	aton
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. las	M	Under 1 Year onths Days	If Under 24 Hr Hours Min	(Month, Day	Year)	9. Birthp	place (State or Foreign ntry)
725	Director		216-76-6299	I X M 2□F	39	Yrs.	511,015	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	June 12	1967		rýland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Locati	on				1	10d. Inside City Limits
	Manyi f sho	ō	Maryland Washir	aton		Нодов	stown					YYes 2 □ No
	28a	rec	10e. Street and Number	ig i on			10f. Zip Code			10g. Citizen o	l What Cour	ntry?
	3a o	by Funeral Director	27 South Locust	S+ An+	1			21740			USA	
	death	ner	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was	Decedent of H		Specify Yes or No-		ace - Americack, White,	can Indian,
9	after or ite	교	1 X Never Married 2 ☐ Married	1 Tes 2 N	lo	i	Yes 2X No	Specify:	no rican, etc.)	Spec		etc.
003	uraf',		3 Widowed 4 Divorced	Year or Dales:						1	W	hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f show fa Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr		1	16a. Decedent	's Usual Occup d of work done NOT use retired	during most of we	orking	16b. Kind of	Business/In	dustry
12	withir Bne. than	E D	Elementary/Secondary (0-12)	College (1-4or 5	+)		Sales C				Retai	1
	Hygi Hygi ant, I		17. Father's Name (First, Middle, Last)			ares o		me (First, Middle,	Maiden Suma		•
an	id be ked of ked of	To Be	Ronald Edmund 7	osadori				Jeann	otto Dr	ent		
Maryland	shou nd M mar umat	-	19a. Informant's Name/Relationship (19b. Mailing A	ddress (Street		lural Route Numbe		n, State, Zip	Code)
	alth a alth a 27 is		Jeannette Tosador	i - Mother		10604 0	ak Tree	e Circle	Willian	sport,	Maryl	and 21795
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.		20a. Method of Disposition	Demouslifrem State	20b. Plac	e of Dispositio	n (Name of ary or other place	ce)	Date	20c. Location	- City or To	own, State
Ē	Pag nent ant: fi ury o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		Smi+	hsburg	Cremato	ory Jan	.16.2007	Smiths	bura.	Maryland
alt	permit. Departr importu eny inju		21. Signature of Funeral Service Lice	nsee					me, P.A.			
_	g Q ≣ 2 9	ļ	(ug/ E	A		425	S. Cond	ococheag	ue St. Wi	lliams	port,	MD 21795
0			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not enter th	ne mode of dyir	ng, such as cardia	c or respiratory are	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Sudden	Death	Unwitn	essed					Criset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):						
		-	Sequentially list conditions, if any, leading to immediate	b. End Sta	ge Kid	dney Di	sease					
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	220 10 (01 20 1	a 00.100qa0.							
	ate be executed hysician end the burial-transit	Xar	that initiated events resulting in death) Last	C. Due to (or as	a consequer	nce of):						
8760,	cate be exitable by the purial of the purial.	dical E	· ·	d								
9	ifficati g phy as the	edic		J								
Вох	The law requires that the death certific at hes been signed by the ettending page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			opic pregnancy	,		23d. D	ate of delive	. ,
	deat	sicia	in the past 12 months? 1 🗆 Yes 2 🗆 No	4☐Pregnant at			her (specify)	y 		, A	Month	Day Year
P.0	that the de led by the e detached t	h.	9 □Unknown									
	res tha igned be det	by	Part II. Dther significant conditions		ut not resultir	ng in the under	rlying cause giv	en in Part I,				he cause of death?
ord	w require been si should l	Completed	Kidney Transpla	nT					1 U Y	es 2∑No	3 Prot	oably 4 ∐Unknown
ec	hes b	npie	Hypertension						24a. Was a autop:	sy	prior to co	ppsy findings available impletion of cause of
<u>=</u>	cate t	S							perfor 1 ☐ Yes	med? 2 XNo	death? 1 ☐ Yes	2 🗆 No
Vita	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0#		ath (Check only or	10)		
of	Phys this al dir	7	1 ☐ Yes 2☑ No 27. Manner of Death	1 _ Inpatie	1	VOutpatient 3	DOA Oth	4 Nursing		ence 6 🗆 O		y)
no	ding P. After funer	lon	1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	28c. Injur Wor	rk? Yes 2∐No	28d. Describe h	ow injury occi	aned	
Division of Vital Records,	i or Attending effer death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not b	e On- Disease of Init	ıry - Al home				28I. Location (S	treet and Nun	ber or Rura	al Route Number.
Ο	al or Att efter d Direct d in by i	erti	4 Homicide	building, etc	(Specify)	-,,	idetery, emoc		City or Tow			
	To the Hospital or Attending Physicien: The within 24 hours effer death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier XX Certifying Pl	nysicien: To the best	ol my knowle	edge, death oc	curred at the tir	me, date and place	e, and due to the o	ause(s) and r	nanner as s	tated.
	n 24 n 24 he Fu	edical	(Check only 2 Medical Examone)	miner: On the basis ol and manner sta	examination ted.	n and/or invest	gation, in my o	pinion, death occ	urred at the lime, o	late and place	e, and due to	the cause(s)
	within To t	Σ	29b. Signature and title of certifier	0			29c. Licens	se number	2	9d. Date sign	ed (Month,	Day, Year)
			X th	1623			DO	0022313		Janua	ry 16	, 2007
A 4 1	1-6		30. Name and address of person who	completed cause of de	eath (Item 23	3a) (Type, Prin	il)					
91	1-5		Eli Roza, M.D.	12931 Oak	Hill	Avenue	Hager	stown, N	Maryland	21742		
	Sta Registr		31. Date filed (Month, Day, Year)		ír's Signatur	9	81 A	Carto.				

ORIGINAL.

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		_ FOI	Certificate of Death	, ,	ene g. No. 2 A A 7	02327	
Physi /Med		1. Decedent's Name (First, Middle, Last) Karen Lee Trent		2. Date of Death January	3ªy 2007	3. Time of Death 5:30p м	
Exam		4a. Facility Name (If not institution, give street and number) 8049 Veterans Hwy. 40 Rol Park	4b. City, Town, or Location of Death Millersville		4c. County of Death Anne Ar	undel	
Funera Directo	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe 1	Months Days Hours Min	8. Date of Birth (Month, Day,) Nov. 8,	Year) 9. Birthp	lace (State or Foreign try)	
ne Maryland 8a-f show otified at	ector	Usual Residence of Decedent 10a. State	Millersville			0d. Inside City Limits 1 □Yes 2 🛣 No	
h with the 23a or 2	al Dire	10e. Street and Number 40 Rol Park Trailer Village	10f. Zip Code 21108	109	g. Citizen of What Coun USA	try?	
ING 21215-UU36 be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, 2 Married 1 □ Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White		
Z1Z15-0U36 within 72 hours af giene. er than "natural", or the Medical Exami	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	king	6b. Kind of Business/Ind	dustry	
iled with	Com	Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	Administration 18 Mother's Nam	e (First, Middle, Ma	State	9	
e de la la la la la la la la la la la la la	To Be	Raymond O. Trent	Helen V	. Gillin	,		
E = 64 F		Raymond O. Trent/Father 14	Mailing Address (Street and Number or Ru. 4 Holly Road, Sever			Code)	
		20a. Method of Disposition 1		1.8.	Oc. Location - City or To Glen Burnie		
Baltimo	325	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Barranco & Sons, P 495 Gov. ritchie H	.A. Sever	na Park Fur na Park, M	neral Home	
Physiciar /Medica	_	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of)	t enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	:				
68 / 60, tificate be executed g physician and as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	:				
Hecords, P.O. Box 68 The law requires that the death certificat the has been signed by the attending phy age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 movems? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ry Day Year	
COLdS, P. w requires that been signed by should be deta	b	Part II. Other significant conditions contributing to death but not resulting in the PATITIS C.) Broker	ne underlying cause given in Part I. D. Sor de R	23e. Did toba 1 ☑ Yes	occo use contribute to the		
	Completed			24a. Was an autopsy performe	24b. Were autoprior to condeath? 1 ☐ Yes	osy findings available npletion of cause of 2 \square	
	å	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FP/Outp.	Other	th (Check only one)	ce 6 □Other (Specify	4	
dlng After	Certification: To	27. Mann Death 1 Latural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year)	ne of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		<i></i>	
DIVISION also or Attents and Director:	Sertific	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,	
LIV To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1	leath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as st te and place, and due to	ated. the cause(s)	
To the within 2 To the complet	×	29b. Signature and title of certifier Stephe Land	29c. License number	7 290	d. Date signed (Month,		
8		30. Name and address of person who completed cause of death (Item 3a) (Ty	(pe, Print)	erna Par	K, mn	1146	
S Regis	tate	31. Date filed (Month, Day, Year) 32/Registrar's Signature	books	- rioc jar	<u> </u>	(10)	
DHMH 17 Rev 1	-	Shirt of Eco.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** Turner ,200T Evelyn Januari 07 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth 9. Birthplace (State or roreign (Month, Day, Year) 11y 29,1922Washington DC Year If Under 24 h 5. Social Security Numbe **Funeral** 1□M 2 F)F Months Days Yrs July Director 84 577-44-3550 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh notified 1 X Yes 2 □ No Maryland Charles
10e. Street and Number Waldorf 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 20603 4742 Hummingbird Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No 9 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Clerk Federal Government 12 marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental 2 Stewart Arthur Saunders Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Pages 1 and 2 tment of Health a Lawrence Turner/Son 4742 Hummingbird Dr Waldorf, Maryland 20603 Department of Healt Important: If item 2 any Injury or other once. itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/11/07 Alexandria, Virginia Metropolitian 22. Name and Address of Facility Adams Funeral HomePA 21. Signature of Funeral Service Licenses Bal Cecil 1348 20605 Aquasco Road Aquasco, Maryland 20608 23a. Part1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** heu mone disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760. physician s the buria Physician/Medical attending p for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has l autopsy performed certificate 1☐ Yes 2FING or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 No 1 Hopatient 2 ER/Outpatient 3□ DOA P this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11855 t gistrar's Signature are Suite 10 Mathur Holly alin

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 2

32

2007

			For State Registrar	State of	Marylaı				ealth an Death	nd Mental		ene	007	02329
181	Dhomini		1. Decedent's Name (First, Middle, La	st)						2. Date Mont	of Death		Vaar	3. Time of Death
	Physici /Medio		Carolyn G. Ton	gue			,			Jan	üary	7 7	2007	2:10 P M
-	Examir	er	4a. Facility Name (If not institution, give		ber)				Location of D	Death		4c. Co	unty of Death	1
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2/4	Funeral Director			1□M 2 X 0F	. 1190 (111)113	58 Yrs.	Months			Min. (Mont	т, Day, У 5 1			nplace (State or Foreign untry) Yland
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	arylar ehow	<u>.</u>	10a. State 10b. County			ity, Town or Lo								10d. Inside City Limits
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9	or ite		1	Armed For	2 X No	1	lf Yes, spo 1 □ Yes	37	n, Mexican, P Specity:	uerto Rican, et	c.)		Black, White	
800	within 72 hours after death with the Maryland ene. Intan "natural", or iteme 23a or 28a-f ehow he Mavical Examiner must be notified a	d by	3 Widowed 4 Divorced	Year or Da	tes:			2LJ NO	эрөспу.			Sp	ecity: B1	.ack
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altimore,	00		20a. Method of Disposition 1 Burial 2 Cremation 3		tate	Place of Dispo	isition (Na ialione)er	other place		Date			ion - City or T	
	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice)		Me	emoria				-12-07	-			, Md.
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	/Medical		disease or condition resulting in death)	a. Due to (c	ras a conse	quence of):	OCA	re gi,	42 2	NEAZ	6776	0~		/hr.
	Examiner		Sequentially list conditions	b. Due to (c	ron	ARY	An	TOR	y T	IFEAS	E			2422
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							_				
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8760,	cate be executed bhysician and the burial-transit			, 220 10 (0		4401100 01/.								
687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai		d										
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregn		Testania s	regnancy				23d	Date of deliv	very
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Š,	signe		Part II. Other significant conditions	Sommouling to dea		-		•						the cause of death?
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g			25. Was case referred to medical						De Blace of	101	res 2	No _		2□ No
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ō	ا قرة		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of		28b. Time of		28c. Injury Work	at ?	28d. Desc				
200	ttendin death. ctor: Af y the fur	catic	2 Accident investigatio	n		.,,,,,	М		∕es 2□No					
	l or Atten after deat Director: in by the	Certification:	3 Suicide 6 Could not be determined	286. Place (of Injury - At h g, etc. <i>(Speci</i>	nome, farm, str fy)	eet, factor	y, office			ion (Street) or Town, S		umber or Rui	al Route Number,
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	To the Hospital or Ati within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examone)	miner: On the bas	sis of examin-	ation and/or in	vestigation	n, in my op	inion, death o	occurred at the	time, date	e and pla	ce, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29	c. License	number		29d	I. Date si	gned (Month,	Day, Year)
)			JEIN S	7.0.				114	749	~		1/	9/07	7
			30. Name and address of person who											
	V		Moirieus Y. LA						1/1	anno,	24 /5			1403
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2007	yishar s Sign	ature	and the					/-	St.	

Registrar DHMH 17 Rev 1/2001

State

CHAGPING 31. Date filed (Month Day, S. HANOVER STREET BALTIMORE, MD

3001

egistrar's Signature

32.

Amended Items 1,29c,29d per Physician, 01/11/2007 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygi	iene	1 00001
				eg. No. 2 U U 1	1 02331
	Physicia	an	1. Decedent's Name (First, Middle, Last) JONATHAN FRANKLIN THOMPSON, JR. 2. Date of Death Month	th Day Year	3. Time of Death
	/Medic		all dentities Themeny (hours of o)	03 200	7-10:2 (M
	Examin	er		4c. County of Dea	th
_		-33	5. Social Security Number 6. Set 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	l o Bir	thplace (State or Foreign
	Funeral Director		1 M 2 F Yrs Months Days Hours Min. 1007h, Days	Year) Co	ountry)
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	yland now at		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	a-fsl	ctor	MD Carroll Hampstead		1 □Yes X No
	or 28)ire	10e. Street and Number 10f. Zip Code 10	0g. Citizen of What Co	
	be filed within 72 hours after death with the Maryland to Hyglene. did they than "natural", or items 23a or 28a-f show deent, the Medical Examiner must be notified at	Funeral Director	2916 Hoffman Mill Road 21074	United Sta	
	tems	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
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2-003	hour tural al Ex			16b. Kind of Business	/Industry
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ַ	othe /ent,	Be C		Maiden Surname)	
<u>a</u>	Aental Aental rked o	To B	Jonathan Franklin Thompson, Sr. Mimi Richards		
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number,	, City or Town, State, .	Zip Code)
	コニトロ		Linda Rill - Daughter 2916 Hoffman Mill Road Hampste		
altımore,	ーエッチ		1 Deurial 2 Commation 3 Demonstrate cemetery, crematory or other place)	20c. Location - City or	Town, State
Ĕ	Pages ment of ant: If It ury or o		4 Donation 5 Other (Specify) Hampstead Cemetery 1/6/2007 H	Hampstead,	
Ball	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funer	al Home, 9	34 South
		-	M00723 Main Street, Hampstead, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre		Approximate
	Dhuaisian		shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	_	
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9	ertifica ing pl	Φ.	0	V	
ROX	leath certific attending p I for use as	jan/	23b. Was decedent pregnant in the past 12 months?	23d. Date of de Month	livery Day Year
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ב.	ires that the de signed by the a be detached t			pacco use contribute to	the cause of death?
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DIVISION OF	Atte	ific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town	reet and Number or R	ural Route Number,
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	To the Hospital or Attending Physician: within 24 hours after deals To the Funeral Director: After this certifica completely filled in by the funeral director;	Medi		are and place, and du	
	5 with 50 00 00 00 00 00 00 00 00 00 00 00 00	2	29b. Signature and title of certifier 29c. License number P19751	01/05/200	Day, Year)
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	13/A		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- 1	/ dis
	Sta		10 31. Date filed (Month, Day, Year) 32. Registrar's Signature	rene St.	PATIMON MI
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, DHMH 17 Rev 1/2001

		For State Registrar		State of	i Marylar		ertificate of L		, ,	Jiene eg. No.2	07	02332
Physicia /Medic		1. Decedent's Nam			. [[2. Date of Dea Month	Day	Year 7	3. Time of Death
Examin	- 1	4a. Facility Name (1					4b. City, Town, or Salisbu			4c. County Wice	of Death	
Funeral Director		5. Social Security N 224-52-56 Usual Residence of	537	Sex 1 X M 2□F	7. Age (In yrs. 89	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year)	Count	ace (State or Foreign try) ginia
1-f show fried at	tor	10a. State	10b. County Wicomi	.co		ty,TownorL Salisbu					10	0d. Inside City Limits 1 X Yes 2 □ No
23a or 28a ust be not	ral Director	10e. Street and Nu 27610 Pe	mber emberton	Drive			10f. Zip Code	01	1	0g. Citizen of \	SA	
Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2∭ Married 4 ☐ Divorced	12. Was Dece Armed Fo 1 X Yes If Yes, Giv Year or D	2 □ No 1	941- 961	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 【 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
sne. Ihan "natur ie Medical I	Completed	Elementary/Seco	15. Decedent's E cify only highest gr ondary (0-12)	ra <i>de completed)</i> College (1	I-4or 5+)		edent's Usual Occupa re kind of work done a DO NOT use retired,		sing	16b. Kind of B		
ental Hygie ked other t ic event, th	To Be Co	12 17. Father's Name Daniel	(First, Middle, Las			1	Military	18. Mother's Nam	e (First, Middle, I	Maiden Surnan		Gaurd
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Depar Impor any in once.		21. Signature of Fi	130 H	serry &	Black	e_{\perp}	22. Name and Addres	n Street	, Salisb	ury, MD		
ysician Medical		shock, or hea shock, or hea Immediate Cause disease or condition resulting in death)	(Final	_a	aused the dea each line. or as a consec	myo	nter the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
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nours afte neral Dir / filled in I		4 ☐ Homicide 29a. Certifier		Daliai	ing, etc. (Speci		ath occurred at the tim	ne, date and place,	City or Town		anner as sta	ated.
vithin 24 h Fo the Fu	Medical	(Check only one) 29b. Signature and			asis of examin ner stated.	ation and/or i	investigation, in my op			late and place,		\-/
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Registr	ar	-	JAN 16	2007	Estima	H. A.	Sparks)					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 22 **Physician** GERALD van den VALENTYN JANUARY 7:39 p^M 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundal Medical Center Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Mar 9 ay 1 9 3 5 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F New York 71 114-28-3496 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other then "neturel", or iteme 23e or 28a-f ehow event, the Mudical Examiner must be notified at 1 ☐ Yes 2 No MD Directo Kent Galena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 32091 Mallard Lane 21635 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 DXYes 2 No 1955 If Yes, Give Year or Dates: -1957 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Town Water & College (1-4or 5+) Elementary/Secondary (0-12) Water & Sewer Maintenance Sewer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 'nent of Health and Mental Walter van den Valentyn Luitgard Ungerer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina van den Valentyn (wife) 32091 Mallard Lane Galena, MD. 21635 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kent Cremation 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If eny injury or once. 1/26/07 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Galena Funeral Home of Stephen 118 West Cross St. Galena, MD. m00510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Bra arc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed attending physicien and afor use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniterumn 24b. Were autopsy findings available prior to completion of cause of death? r this certificete has sral director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Inpatient 2 1 Tyes 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours. the Funeral Dire 162 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ANAPOCIS MA eath (Item 23a) (Type, Print) 10+1 30. Name and address of person who completed cause 2104 Just ARRINDEZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Mark Antonio	Washington
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		1- For State Registrar	Certificate	e of Death	7.0	eg No. 200	7 0 7 1 3
Physici Medical Exami		Decedent's Name (First, Middle,Last) Mark Anton	io Washington		2. Date of Dear Month January 3	h Day Year	3. Time of Death 1949 hrs
perma		4a. Facility Name (if not institution, give street	and number)	4b. City, Town, or Location o	f Death	4c. County of Death	10401113
Funeral		Interstate 295 at Route 450 Sout 5. Social Security Number 6. Sex	th Bound 7. Age (In yrs. last birthday	y) If Under 1 Year If Under	Odles To Date of Die	Prince George	
Funeral Director		577–96–8333		y) If Under 1 Year If Under Months Days Hours Yrs.	Min	th (MM/DD/YYYY) 9 Birth Foreign 7, 1963	
daryland 28a-f show any 1 at onee.	or	Usual Residence of Decedent 10a. State D•C• 10b. County	10c City, Town or L	ocation Washington	l		10d Inside City Limits 1 Yes 2 No
h the Maryland 3a or 28a-f sho otified at onee.	Director	10e. Street and Number 440 Ord Street, N.E.	<u> </u>	10f. Zip Code 2001		Og Citizen of What Coun	try?
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene riked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Ari	ned Forces? Yes 2 X No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, Yes 2 X No specify		14 Race - Americ White, etc.	_
72 hours afte n "natural", al Examiner	Completed by	15. Decedent's Education (Specify only higher	st grade completed) 16a. Dece	edent's Usual Occupation (Give king most of working life, DO NOT u	ind of work done use retired)	16b. Kınd of Business/lr	
5-0036 Ited within 72 Hygiene forther than '	dwo	11th grade 17. Father's Name (First, Middle, Last)	Ur	remployed		N/A	
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	Be C	Charles M. Washin	gtan	18.Mother's	Name (First, Middle, N Peggy	laiden Surname) J. Curry	
2 Pa & E S	To	19a Informant's Name/Relationship (Type, Pry Mr. Craig A. Washington (alling Address (Street and Numi JZ Quarles Street,			019 °de)
s l an of Heal If iten		20a Method of Disposition 1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other Specify	oval from State 20b. Place of Dis	sposition (Name of cemetery, of other place) Memorial Park	January 20, 2	20c. Location - City or 007 Landover	
		21 Signature of Fungral Service Licensee	12	22. Name and Address of Facility 4339 Hunt Place, N.	Rollins Fune E. Washingtor	ral HOme, Inc. 1, DC 20019	
Physician /Medical		23 art I. Enter the disease, or complications failure. List only one cause on each line.			rdiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner			ot Wounds (2) of Neck ar or as a consequence of):	nd Chest			Bealit
	ner	Sequentially list conditions, if any, leading to immediate Due to (continuous list)	or as a consequence of):				
xecuted n and - transit	Examiner	(Disease or injury that initiated C.	or as a consequence of):				
10, e be exect ysician an	dical	UNPENDED AMEN	DED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		23b Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic Other (Specify)	pregnancy	23d Date of delivery Month Da	ay Y ear
D.O. Bo that the de ned by the detached f		Part II. Other significant conditions contribu	Unknown iting to death but not resulting in t	the underlying cause given in Par	11. 23e. Did tol	pacco use contribute to the	ne cause of death?
S, P.C uires that n signed	ed by				1 Yes	2 No 3 Proba	ably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirms after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed				24a. Was a autops perfort 1 ✓ Yes 2	prior to co ned? death?	opsy findings available impletion of cause of
ital Fieinn: s certifi rector,	Bec	25. Was case referred to medical examiner?		26 Place of Death (0			
n of VI ling Phys After this funeral di	5	1 ✓ Yes 2 No 27. Manner of Death 28a	Inpatient 2 ER/Outpat Date of Injury 28b. Time			Residence 6 Other	Scene
tendin death stor: A y the fu	atior	1 Natural 5 Pending Jal 2 Accident Investigation	(Month Day, Year) 1 3, 2007 1930 hrs	1 Yes 2 🗸 1	Subject shot		
Divis spital or At nours after d neral Direc	Certification:	4 Momicide determined (Sp.	Place of Injury - At home, farm, secify) Major Road / Highv		or Town, St	treet and Number or Rura ate) 450 SB, Bladensberg	
To the Hos within 24 h To the Fu	Medical	one) 2 Medical Examiner: On the	ne best of my knowledge, death or pasis of examination and/or investance stated				
+ 3 + 3	Me	29b. Signature and title of certifier Milana Brassell v	4.5	29c, License number O.C.M.E.		29d Date signed (Mont	h, Day, Year)
CR	ļ	30. Name and address of person who complete Melissa Brassell, MD Assistan	,	1 Penn Street, Baltimore,	MD 21201		
St Regis	ate		32 Registrar's Signature				

07-00481 John Lee Way

omi Lee vvay			artment of ertificate of	f Health and f <i>Death</i>	Mental F		20	07 0223					
Physic Medical Exam	ian/ iine					2. Date of Dea		3 Time of Death					
and		JOHN LEE WAY 4a. Facility Name (if not institution, give street and number)		4b City Town and		January 1		2021 hrs					
		Harbor Hospital Center	1	4b. City, Town, or L Baltimore	ocation of Deat	h	4c. County of	Death					
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24Hr	s 8. Date of Bir	th(MM/DD/YYYY)	9 Birthplace (State or					
Director		578-54-3542 1XM 2 F 65	Yrs	Months Days	Hours Mir	1	2/1941	Foreign Country) SC					
any		Usual Residence of Decedent 10a. State 10b. County 110c. City	, Town or Locati				-7-27-12						
#	_	Toc. Gity.						10d Inside City Limits					
Maryland 28a-f show 1 at once,	Director	MD Prince Goerge's S 10e Street and Number	uitland	10f. Zip Code			02 04 (144	1 X Yes 2 No					
the A Sa or S	ä	6020 Maria Avenue		20746		l '	0g Citizen of Wha	t Country?					
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?		s Decedent of Hispa	anic Origin? (S	pecify Yes or No		American Indian, Black,					
er dea			IT Y	es, specify Cuban, N	Mexican, Puerto	Rican, etc.)	White,	etc					
urs afi tural* amine	d b	or Dates:		Yes 2 X No			Specify B	lack					
6 72 ho m "ma sal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	t's Usual Occupation ost of working life, D	O NOT use ret	work done ired)	16b. Kind of Busi	ness/Industry					
5-0036 Iled within 7: Hygiene other than	μď	12	Opera	tions Mgr	· •		Automot	ive					
21215-0036 unld be filed within 7 Mental Hygiene marked other than c event, the Medical	Be Co			18	Mother's Name	(First, Middle, M	laiden Surname)						
D 2121; should be fill and Mental F is marked	o B	Rubin Way 19a Informant's Name/Relationship (Type, Print)	19h Mailing	Address (S)	Mary M	. Clybur	n						
MD d 2 sho lth and n 27 is		Barbara J. Way / Wife	6020 M	Address (Street a	na Number or P Nue: Si	Rural Route Num $\mathtt{uitland}$,	ber, City or Town, MD 207						
Baltimore, MD 2.7 permit. Pages I and 2 should Department of Health and Mt Important: I friem 27 is and injury or other traumatic ex		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		tion (Name of cemet		Date	20c Location - C						
Limo Page ment c		4 Donation 5 Other Specify:	ncoln Me	'	01/	24/2007							
Ball permit Depart Impor	ì	21. Signature of Funeral Service Licensee	22. Na	ame and Address of	Facility		Suitlan	a Avenue N.W.					
Physician		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.		ney's Fur									
/Medical	М						st, shock, or heart	Approximate Interval Between Coset and					
Examiner		Immediate Cause (Final disease or condition resulting in death) Hypertensive atherosclerotic cardiovascular disease Between Crise and Death Due to (or as a consequence of):											
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of											
	miner	if any, leading to immediate Due to (or as a consequence of) Cause. Enter Underlying Cause (Disease or injury that initiated C):										
nsit ed	Exal	events resulting in death) Last Due to (or as a consequence of)):										
ords, P.O. Box 68760, aw requires that the death certificate be executed tas been signed by the attending physician and 2 should be detached for use as the burial - transit		d. X UNPENDED AMENDER OF											
760, icate be physici the buri	Medical	IF FEMALE 23b. Was decedent preparation the	E g864, 2,	/12/07 TT									
Sox 687 death certific e attending p	sician/	23b. Was decedent pregnant in the past 12 months?	2 Feta		Ectopic pregnar	псу	23d. Date of del Month	Day Year					
Box le death c the atten ed for us	ysic	1 Yes 2 No 9 Unknown Pregnant at time of dea	othe 5 Othe	er (Specify)				- Jy					
O nat the d by the etaches	y Phy	Part II. Other significant conditions contributing to death but not res	sulting in the und	derlying cause giver	n in Part I.	23e. Did tob.	acco use contribut	e to the cause of death?					
S, P.(ed by							Probably 4 V Unknown					
tal Records, cian: The law require certificate has been si	Completed			· · ·		24a. Was an	24b. Were	e autopsy findings available					
Rec The I	팃					autopsy perform	ed? deati						
tal ician: certif rector,	Be	25. Was case referred to medical examiner?		26 Place of D	Death (Check or	L	INO 1	Yes 2 No					
of Vital ing Physician: After this certif uneral director,	2	1 V Yes 2 No Hospital 1 Inpatient 2 V E				Home 5 R	esidence 6 0	ither:					
on of ending Pl ath. rr: After he funeral	ig.	27. Manner of Death 1 X Natural 5 Pending 28a Date of Injury (Month, Day, Year)	28b Time of Inju	1	1	28d. Describe ho	w injury occurred						
Division tal or Attendi rs after death. al Director: A	fica	2 Accident Investigation	ne farm street	1 Yes		201							
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify)	no, idim, succi,	ractory, office builds	ng, etc.	or Town, Star	eet and Number or te)	Rural Route Number, City					
To the Hos within 24 h To the Fun completely	4	29a. Certifier 1 Certifying Physician: To the best of my knowledge one)	e, death occurred	d at the time, date a	nd place, and d	ue to the cause/	s) and manner as a	ntoto d					
To tl withi To th	ᄝᆫ	and manner stated	d/or investigation	n, in my opinion, dea	th occurred at	the time, date an	d place, and due to	the cause(s)					
		29b. Signature and title of certifier		29c License nur		2	9d Date signed (Month, Day, Year)					
	Ļ	Hamily Jumul, mo		O.C.M.E			January 18, 20)07					
		30. Name and address of person who completed cause of death (Item 23 Pamela E. Southall, MD Assistant Medical Exam		Penn Street, Ba	altimore NAT	21201							
Sta	te	31. Date filed (Month Day Year) 2007 32 (egistrar's Signature											
Registr	ar	MIN W 4 COUL PROPERTY	FIRM										

7-00511 tephen Peter Wh	itney Sta	e or Print in E ate of Maryland	d / Departm	nent of H	ealth an			egible.		0000		
	1- For State Registrar		Certific	cate of D	eath			Reg. No.	U/	UZJJ		
Physician Medical Examine	Stephen Peter	Whitney					2. Date of De Month January	Day Yea 18, 2007	-	Time of Death 2300 hrs		
	4a. Facility Name (if not institution 316 Pretty Man Drive	n, give street and numbe	er)		City, Town, or ockville	Location of	Death	4c. County of Montgon				
Funeral Director	5. Social Security Number 155–38–4344	6. Sex 7. A	Age (In yrs last bi		Under 1 Yea Nonths Day		24Hrs 8. Date of 8 Min. 12/03	/1948	9. Birthpla Foreign N Country	lew Jerse		
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lth and Mental Hygiene. n 17 is marked other than "natural", or items 23a or 28a-f show any numatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specementary/Secondary (0-12) 17. Father's Name (First, Middle, Douglas Arthu	s Walk Cour 12. Was Deceder Armed Force: 1 Yes orced If Yes, Give Year or Dates: cify only highest grade or College (1-4 or 4 Last) r Whitney nip (Type, Print)	nt Ever in U.S. 2 X No completed) 16a or 5+)	13. Was De If Yes, s 1 Yes Decedent's L during most of System	f. Zip Code 20878 seedent of His specify Cubar s 2 X No Isual Occupat of working life s Engi	n, Mexican, F specify: tion (Give ki DO NOT u neer 18 Mother's Fann	n? (Specify Yes or Neuerto Rican, etc.) Ind of work done se retired) Name (First, Middle ie S Soloper or Rural Route Nace, Rock	White Specify 16b Kind of Bu Compute, Maiden Surname) mon	State - American I e, etc. White siness/Indus er Tec	Indian, Black. Stry hnology Code)		
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	20a Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Sp 21 Signature of Funeral Service	3 Removal from Secify:	State 2Cb. Place crems	of Disposition atory or other particular columns of the columns of	(Name of cerolace) Crema e and Address 1e Tri Rockv	tory s of Facility bute ille	Date 1/23/2007 Funeral a Pike, Roc	Brentw nd Cremat kville, M	vood, ion C	n, State		
Physician /Medical xaminer	23a. Part I. Enter the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart befure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unseas or injury trat imitiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfer of certification: To Re Completed by Physician/Medical		e 23c. If yes, outce 1 Live birth 4 Pregnant g Unknown	3a, 27, 28a- come of pregnance at time of death	2 Fetal d	(Specify)		pregnancy	23d. Date of Month tobacco use contries 2 No 3	Day bute to the c	Year rause of death?		
ital Records, P.C. ician: The law requires that s certificate has been signed rector, page 2 should be det. Re Commisted by	25. Was case referred to medical examiner?	Hospital:	61-14 O TED			Othor	1 Yes	opsy promed? d	erior to compleath? Yes	y findings available letion of cause of 2 No		
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should the	1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident Inves 3 Surcide 6 X Coul 4 Homicide	28a. Date of Ir (Month, Day stigation donot be	njury y,Year) 28b 8/2007 Fr Injury - At home, found at h	nome	28c. Inju	ry at Work? Yes 2 X 1 puilding, etc.	unknown 28f. Location or Town, Rockvil	le, MD	ed er or Rural R retty M	oute Number, City		
To the How within 24 h To the Fur completely	29b Signature and title of certifies Potrucia 30. Name and address of person Patricia Aronica-Pollal	miner:On the basis of exand manner state r who completed cause of	xamination and/ord	investigation,	29c. Licens	n, death occi se number M.E.	urred at the time, dat	e and place, and d 29d. Date signe January 19	ue to the cau			

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month Pay Year) 2007

Amended Item 2 per M.E. 01/17/2007 Carroll County, wjl Amended Items 2,23b,25,26,28b per M.E. 01/16/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		State of Ma	aryland	•	rtment of F tificate of	lealth and M <i>Death</i>		giene () ()7	023	37
		1. Decedent's Name (F	First, Middle, La	ist)					2. Dorobia		2006	3. Time of	Death
Physic /Medi		Meredith 1	Richard	son Wilson					Januar		388 7	1:45	A^{M}
Exami		4a. Facility Name (If no	ot institution, gi	ve street and number)			4b. City, Town, o	r Location of Death	-Januar	4c. County	y of Death		
		Blakehurs	t Retir	ement Livi	ng		Towson			Balti	imore		
Funeral		5. Social Security Num			e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	v. Year)	9. Birthpl Coun	ace (State o	r Foreign
Director		213-10-89	99	MOM 2□F	91	Yrs.		7,0010	10/19/	1915		land	
pud *		Usuel Residence of De 10a. State 10	ocedent Ob. County		10c City	Town or Loc	cation				10	od. Inside Ci	by Limits
aryla •ho	5				_		211011					1 🗀 Yes	
he N	Director	MD 10e. Street and Number	Baltimo	ore	Tows	OH	tot Zin Codo			10g. Citizen of	NA/h at Causa		
with	ă						10f. Zip Code			United		•	
eath re 23	Funeral	1055 West	Joppa	Road 12. Was Decedent	Ever in II S	13 V	21204	lispanic Origin? (Sp	noity Vas or No.		ce - Americ		
Iten d	Ľ	11. Marital Status 1 ☐ Never Married	2 Married	Armed Forces?	1947		Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		ick, White,		
urs at	by F	3 ☐ Widowed 4 [If Yes, Give Year or Dates:	1946	1	☐ Yes 2☐ X io	Specify:		Specia	^{'n} ∵ Whi	te	
If Z I Z I 2-0000	Ped		5. Decedent's E			16a. Deced	ent's Usual Occup	pation		16b. Kind of B	Business/Inc	lustry	
nin 7.	Completed	(Specify Elementary/Seconda		ade completed) College (1-4or 5	(A)	(Give : life. D	kind of work done OO NOT use retired	during most of work d)	ing			•	
filed with Hygiene other the	ĕ		a.y (0 .2)	4	'	A:	torney			Law F	irm		
A SHAPE	Be	17. Father's Name (Fir	rst, Middle, Las	t)			-	18. Mother's Name	First, Middle,	Maiden Sumai	me)		
should be nd Mental marked o	2	David H.	Wilson					Annie E	lizabeth	n Richar	rdson		
and and		19a. Informant's Name	•					and Number or Rura				Code)	
end 2 end 2 leelth m 27 her tr				shfeld-Daug					illers,	MD 2110	02		
T SE T	1 2	20a. Method of Dispos		Removal from State	20b. Pla	ice of Dispo: metery, crem	sition (Name of natory or other place	сө)	Date	20c. Location	- City or To	wn, State	
Pages ment of ant: If its ury or o		4 Donation 5			Drui	d Rid	re Cemete	ery 1/5/2	2007 E	altimo	re, Ma	rylan	d
permit. Pages Deperment of Plinportant: If ite any injury or of ores.		21. Signature of Fune	ral Service Lice	insee		22		ss of Facility E1:		eral Ho	me, 93	34 Sou	th
0 40E#a		Stev	en U	1. Elmi	MOO	723 M	ain Stree	et, Hampst	tead, M	21074			
		23a. Part1. Enter the shock, or heart fa	disease, or cor ailure. List on	plications that caused one cause on each li	the death.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximat Interval Bet	ween
Physician		Immediate Cause (Fir disease or condition	nal	TATA	CRAN	no 15	UB An AT	HNILL HE	Descript 4	in-/	, l	Onset and I	Death
/Medical		resulting in death)	-	Due to (or as	a conseque	ence of):	<u> </u>	HNUID ITE	BRUCA	itamo	7****		
Examiner		Sequentially list condi	tions	b. FRUI	tems	TYLA	Jung				Cirn	50	1745
ש ב	Examiner	Sequentially list condi- if any, leading to imme cause. Enter Underlyi Cause (Diseese or inju	ediate ing	Due to (of as	a conseque	ence of):							
ecute and trans	am	Cause (Diseese or injuithat initiated events resulting in death) Las		c									<u>.</u>
olen a	û	rooding in doding East	^	Due to (or as	a conseque	ence of);							
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	/Me	IF FEMALE:		23c If was outcome	of preonen	014							
The Cord Las, F.O. BOX of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pr in the past 12 mo		23c. If yes, outcome	2 Fetal o	death 3	Ectopic pregnancy	y			ate of delive onth	,	Year
bed bed	ysic	1 ∐ Yes 2 ⊠1 9 ∐ Unknown	-	4⊡Pregnant at 9□ Unknown	ame or dea	aun 5_	Other (specify) _						
that the ded by		Part II. Other significa	ant conditions	contributing to death b	ut not resul	ting in the ur	deriving cause giv	ven in Part I.	23e. Did to	bacco use con	tribute to th	e cause of d	leath?
signe d be o	d by	CORONA	ny As	yony Dist	5	ANTO		0715	1 🗆 Y			ably 4 🗆	
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ne lav	Completed		ITENS						24a. Was autop		prior to condeath?	sy findings apletion of c	available ause of
Iclen: The		AURTI		30515					1 Yes	2XNo	1 Yes	2 N o	
VIII sicie certif	Be	25. Was case referred examiner?	to medical	Hospital:			3 DOA O#	26. Place of Death					
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or Attending effer death. Director: After in by the fune	ertification	1 Natural 2 Accident	5 Pending investigation	(Month, Da	Year)	Injury 0:45	28c. Injui Wor	rk? Yes 2 No	Fre	on injury cood			
Atter dea octor	fica	3 Suicide	6 Could not	28e. Place of Ini	urv - At hon	ne, farm, stre	-		28f. Location (S	Street and Num	ber or Rura	Route Num	ber.
d in the	ert	4 Homicide	dotollilitio	" building, et	c. (Specity)	1	MCE HUN	Į.	City or Ton	m, State)			
spita nours neral	a C	29a. Certifier 1	Certifying P	hysician: To the best	of my know	ledge, death	occurred at the til	me, date and place.	and due to the	cause(s) and m	anner as st	ated.	
To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 ^f [one)	Medical Exa	miner: On the basis o	examination	on and/or inv	estigation, in my o	ppinion, death occur	ed at the time,	date and place,	and due to	the cause(s)
To th To th comp	Me	29b. Signature and titl	e of certifier	traf)		29c. Licens	se number 101)	/	29d. Date signe	ed (Month I	Dey, Year)	
11/2	A	• (Linut	ADI	-	La	DO	518350	-(1/3/	07		
MATT		30. Name and address	s of person who	completed cause of c	eath (Item :	23a) (Type,	Print)			- / - /	-		
		VINCE	_	. ^				20 Tows	son wi	D 2120	Y		
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Regist	rar		JAN 1 6	2007	eva	B.	porte						
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DHMH 17 Rev 1/2001

			For Stata Registrar	State of Marylar			nt of H te of L		nd Me		jiene	007	02338
¥2.	Physici /Medio	an	1. Decedent's Name (First, Middle, La. John Joseph W	allace						2. Date of Dea Month	Day - 1 -	-07	3. Time of Death
2.5	Funeral		4a. Facility Name (If not institution, give Carroll Hospit 5. Social Security Number 6. S	al Center ex 7. Age (In yrs.	Yrs.	W	estm er 1 Year	inste	er 4 Hrs. 8 Min.	B. Date of Birth (Month, Day	Ca Year)	Co	hplace (State or Foreign untry)
*e**	Director Mou		216-20-9227 Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo	cation				June :	29	1926	MD 10d. Inside City Limits
	with the Ma a or 28a-f s	Directo	MD Carr 10e. Street and Number		Westmi		ip Code					zen of What Co	1 ☐ Yes 2 ☐ No untry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental rhygiene. If item 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, the Medical Examinar must be multiled at	Completed by Funeral Director	2526 Old Wash 11. Marital Status 1 ☐ Never Married 2 ☑ Marned 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U	$W \perp \perp \perp$		2115 edent of Hi ecity Cuba	spanic Origi n, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		A. 14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	filed within 72 ho Hygiene. other than "natur. ant, the Magical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1.2	College (1-4or 5+)	life.	kind of v DO NOT	rork done d use retired	du <i>ring</i> most o	ster	er	Ros Hos	spital	Industry State
aryland	2 should be filed vand Mental Hygie is marked other raumatic event, II	To Be	17. Father's Name (First, Middle, Last, John Josep 19a. Informant's Name/Relationship (h Wallace,	Sr 19b. Maili	ng Addre	ss (Street a	Anita	a Mo	(First, Middle, ylan Route Numbe			Zip Code/21157
Baltimore, M	Pages 1 and 2 nent of Health a ant: if item 27 is ury or other tra		Mary Marya 20a. Method of Disposition 1 Sturial 2 Cremation 3 C 4 Donation 5 Other (Specif	Removal from State	/wife Place of Dispo commetery, cres	natory o	ame of other plac	е)	Da	ite	20c. Lo	cation - City or	
Balt	permit. Page Depertment important: if eny injury o		21. Signature of Funeral Service Liber	nsee	2	Prit 412	Ts F Wash	uner ungt	al H on F	Home a Road	nd Wes	Chapel	, P.A. er,MD21157
	Physician /Medical Examiner prize pr	Examiner	23a. Pak1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	STIVE quence of):	H	-APT	FA	-1 L .u	RE	est,		Approximate Interval Between Onset and Death
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Q _	quires that the signed by and be detacted	by	Part II. Other significant conditions of	contributing to death but not research FALLI						23e. Did to			the cause of death?
of Vital Records,		Completed	CHRONIC	OBSTRUCTIVE	Риц	~~^	ARY	DISE	ASE.	24a. Was a autop. perfor	sy		utopsy findings available completion of cause of
Vita	Physicien: This certificate ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			1 04		of Death	(Check only o	ne)		
of	S = D	2	1 Yes 200No	1 Inpatient 2 28a. Date of Injury	ER/Outpatie			4 🗀 (40)		-		Other (Spe	cify)
Division	ath. ar: After	Certification:	1 Natural 5 □ Pending 2 □ Accident investigatio 3 □ Suicide 6 □ Could not be	(Month, Day Year)	Injury	М		yat k? Yes 2□N	lo	Bd. Describe h Bf. Location (S			ural Route Number,
Ö	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the		29a. Certifier 1 Certifying Pl	nysician: To the best of my kn	owledge, dea	th occurre	ed at the tin	ne, date and	I place, ar	City or Tow	ause(s)	and manner as	s stated.
	n 24 I	edical	(Check only 2 Medical Exal one)	miner: On the basis of examin and manner stated.	ation and/or ir	vestigati	on, in my o	pinion, death	n occurre	d at the time, o	date and	place, and due	to the cause(s)
)		Z	29b. Signature and title of certifier	nde	2	2	9c. Licenso	number 926	3			e signed (Mont	
	Marin		30. Name and address of person who FRANCIS KHOOL 31. Date filed (Month, Day, Year)	70	30 ME	Print)	IAL	quen	NE	WEST	min	USTER,.	MO 21157
1.68	Sta Regist		IAN 1 6		At .	1	w						

			1 - For State Registrar	State of Ma			nt of H	ealth ar		al Hygie		02339
			1. Decedent's Name (First, Middle, Las	t)						ate of Death	Day Yea	3. Time of Death
	Physici /Medio		Mary Ann	Weeks							17, 2007	
`	Examir		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of	Death		4c. County of De	eath
			38 Fibiwee Lane					ake Pa			Garrett	
	Funeral Director		5. Social Security Number 6. S 199-25-9514 Usual Residence of Decedent	ex 7. Age □ M 2☐ F 7.	(In yrs. last birthda Yrs.	Month:	er 1 Year Days	If Under 24 Hours	Min. (N	ate of Birth fonth, Day, Y	^(ear) 1931 Pe	Birthplace (State or Foreign Country) nnsylvania
	land ow		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	Mary field	to	MD Garre	tt	Mtn.	Lake	Park					1 ☐ Yes 2 No
	h the	Funeral Director	10e. Street and Number			10f. Z	ip Code	-		109	g. Citizen of What	Country?
	23 c	alD	38 Fibiwee Lane				2155	0			United S	tates
	dea fin	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	3. Was Dec	edent of Hi	spanic Origi	n? (Specify Y Puerto Rican	'es or No-	14. Race - A Black, W	merican Indian,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Independent than "netural", or items 23e or 28e-f show event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	0			Specify:		, 010.7	Specify:	hite
5	72 h netu	Completed	15. Decedent's Ed (Specify only highest gra		(Gi	cedent's Us	rork done a	lurina most c	of working	16	b. Kind of Busine	ss/Industry
21	of thin	dr.	Elementary/Secondary (0-12)	College (1-4or 5-	life	DO NOT	use retired,)				
2	e filed within al Hygiene. I other than " vent, the Me	ပိ		2	Н	omema	ker				Own Home	
밀	be fill H	Be	17. Father's Name (First, Middle, Last)					18. Mother:	s Name (Firs	t, Middle, Ma	aiden Sumame)	
돌	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked sny injury or other treumatic ex 9069.	မ	John Merle	Cook				Mary			ohrbaugh	
Jar	and and		19a. Informant's Name/Relationship (7								City or Town, State	
	l and lealth im 27		Mr. Merle M. Wee	ks	68 20b. Place of Dis			ne, Mi	tn. La		k, MD 21	
Baltimore,	t of t		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, c	ematory of	other place	9)	Date	20	c. Location - City	or lown, State
Ë	men tant: jury		4 ☐Donation 5 ☐ Other (Specify		Garrett					7 0	akland,	MD
Sai	Depar Impor Impor any in		21. Signature of Funeral Service Licen	see		22. Name	and Addres	s of Facility	Burdo	ck-Dur	st Funer	al Home
	40 = 0		Katherine	Skeiter			2	21 N.	Second	_St.,	Oakland,	MD 21550
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	consequence of):	enter the mo		g, such as ca	ardiac or resp	oratory arres	t,	Approximate Interval Between Onset and Death
3760,	te be executed ysicien and le burial-transit	Ical Examiner	Sequentially list conditions, large leading to humadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):							
.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal death 3	B□Ectopic i□ Other (s					23d. Date of o	delivery Day Year
<u>α</u>	quires that n signed b uld be deta	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying	causa give	n in Part I.	2	3e. Did toba	.)	to the cause of death? Probably 4 □Unknown
l Records,	Page 1	Completed							_	4a. Was an autopsy performe □ Yes 2	prior t ed? death	autopsy findings available o completion of cause of ? es 2 \(\) No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?		V. D. C. C.				of Death (Che		No el T	
o To	hysic his ca I dire	P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatier	it 2 ☐ ER/Outpat	ent 3 🗆 🛭	OA Othe	r: 4 🗆 Nurs	ing Home	Residence	e 6 Other (S	pecify)
ion o	Attending Pi r death, ector: After ti by the funera	atlon:	27. Manner of Death Natural 5 Pending Accident investigation	1	Year) 28b. Time Injury		28c. Injury Work 1 □ Y	at ? ∕es 2 □ No		escribe how	injury occurred	
Division	P S S	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, (Specify)	street, facto	ry, office		28f. Lc	ocation (Stre ity or Town,	et and Number or State)	Rural Route Number,
	To the Hospitel or within 24 hours effe or To the Funeral Dir completely filled in	edical	29a. Certifier Contifuency Ph (Check only one) 2 Medical Example 1	ysician: To the best of niner: On the basis of and manner stat	examination and/or	ath occurre investigation	d at the tim n, in my op	e, date and inion, death	place, and du occurred at t	ie to the cau he time, date	se(s) and manner and place, and d	as stated, ue to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	A		2	9c. License	number		29d	. Date signed (Mo	nth, Day, Year)
)			> / Cent	Eugh.			16	180	11		1/17	107
			30. Name and address of person who of Ken R. Buczyn	2			h Str	eet.	Suite	l. Oak	land. MD	21550
	Sta Registi		31. Date filed (Month, Day, Year) JAN 17	32. Reģistra		Arrah				J		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 23a,b,25 per Overif 6865 of Wellto / 07dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 7:24 PM harles 15 2007 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 405 OKINS 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F Yrs 60 Director 218-48-5407 March 31, 1946 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medi-al Examiner must be notified at 1 ☐ Yes 25 No Director MD Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9590 Old Railroad Road 21837 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 22 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Grain & Produce 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental I Important: If item 27 is marked any Injury or extending the permitted of the Charles M. Wright, Jr. Frances Shockley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy S. Wright 9590 Old Railroad Road Mardela Springs, MD 21837 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva Jan. 17, 2007Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee Delmar, DE 13 E. Grove Street ease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a. Part1. Enter the di shock, or heart fail Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** exebical Hernicition /Medical Due to (or as a consequence of): Intracranial Hemorrhage Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) certificate be executed MEDICAL EXAMINER burial-tran Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician d be detached for use as the buris Physician/Medical CERTIFICATION APPROVED BY IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No lomo page 2 has autopsy perform certificate 2 No or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes - New Yes 1 Inpatient 7 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. al or Attend s after death. filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007

State Registrar 21. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Appendix

DHMH 17 Rev 1/2001

Baltimore

MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GREGORY FRANKLIN WALLACE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REGIONAL Medical Sallsbur Wiconics PENINSULA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 215-58-5068 55 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or Itama 23a or 28a-f ahow treumatic avant, the Madical Examinar must be notified at 1 Yes 2 No Director MD WICOMICC ALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 21801 USA IIMES Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: BLACK Specify: þ 3 ☐Widowed 4 ☐Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use vatired)

16b. DO NOT use vatired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HRINTING CO. STANDARD RECHSTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HANDY DANNE FRANK WALLACE ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1619 CYPRESS ST. LAUREL, MD MICHAEL WALLACE 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or once. 20-07 SALISBURY, MD 21801 4 Donation 5 Other (Specify) me and Address of Facility
SSICK FUNERAL HOME PO BOX 61 BIVALVE, MD
21814 21. Signature of Fyneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner CARDIAC THROMBUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physicien and of for use as the burial-transit law requires that the death certificate be executed INFARCTION MYDCARDIAL that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ARTERIAL OCCUUSIVE IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) cate hes been signed by the t page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYDPATHY, CVA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate hes autopsy performed? 2 No 1 Yes or Attending Physician: Director: After this certification by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 3 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funerel Direct completely filled in by filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 163433 1114/07 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 106 MILFORD ST, SLUTE SO4B, SAUSBURY NEMAL DOSHI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 17 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13, 2007 Year Month Bertha Rosa Zepeda 6:00 a. January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick 2181 Westmarch Court Frederick 8. Date of Birth (Month, Day, Year) Nov. 27, 1920 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Months Min. El Salvadore Hours Days 219-15-3032 86 Yrs Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland | Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2181 Westmarch Court 21702 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 X Yes 2 □ No Specify:El Salvadorian Specify: Hispanic 3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Guadalope Segovia Tomasa Hernandez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juan C. Ortiz/Grandson 2182 Westmarch Court, Frederick, Md 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resthaven Mem Gards 1/16/2007 Frederick,MD 22. Name and Address of Facility 21. Signatury of Funeral Service Licenses Stauffer Funeral Home, PA Live 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACCINENT CENEBRAL VASCULAN Due to (or as a consequence of): THRIVE AILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Examiner

Completed by

Medical

29b. Signature and title of certifier

>1(M)-

2007

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

and for use as the burial-trai attending physician Physician/Medical cate has been signed by the page 2 should be detached certificate funeral director Certification: To Be After this death. the 24 hours after death Funeral Director:

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

			1 Yes 2 No 3 Probably 4 Onkno			
			24a. Was an autopsy performed? 1 Yes 2 1 Vos 2 Vo			
		26. Place of De	eath (Check only one)			
lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Home 5 NResidence 6 □Other (Specity)				
28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At he building, etc. (Specil	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Place of injury - At home, farm, street, fact building, etc. (Specify)	dospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office			

Hospital or Attending Physician:

State Registrar

filled in by

completely

within 24

47951

29c. License number

29d. Date signed (Month, Day, Year) 01-15-2007

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) HOUSE AVE. FREDERICK. BIY TOLL A. KAZMI 31. Date filed (Month, Day,

	1 - State of M		nent of Health and loate of Death	Mental Hygie	2007 02313
Physician /Medical	1. Decedent's Name (First, Middle, Last) DENZAL KUFFAUR ANDR	EWS		2. Date of Death Month January	Day Year 3. Time of Death 2.7 20.0 7 12:4 3p
Examiner	4a. Facility Name (If not institution, give street and number, Greater Baltimore Medic	cal Center	City, Town, or Location of Death Towson Index 1 Year If Under 24 Hrs.		4c. County of Deeth Baltimore
Funeral Director	5. Social Security Number 6. Sex 1 □ MM 2 □ F 7. All Usual Residence of Decedent		hths Days Hours Min.	8. Date of Birth (Month, Day, Ye 12/31/0	9. Birthplace (State or Foreign Country) 6 MARYLAND
Kuffactor	10a. State 10b. County MARYLAND BALTIMORE 10e. Street and Number 1717 White Oak Avenue 11. Marital Status 12. Was Decedent Armed Forces	t Ever in U.S. 13. Was [10d. Inside City Limits 1 ☐ Yes 2 ☑ No Citizen of What Country? USA 14. Race - American Indian, Black, White, etc.
21215-003(21215-003(21215-003(21215-003(within 72 hours a liene than "natural", o	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 HYes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	No 1 □ Y	es 2 No Specify: Usual Occupation of work done during most of work OT use retired)	UNKNOWN 16E	Specify: WHITE NAME OF Business/Industry
re, Maryland 2 st and 2 should be filed Health and Mantal High Item 27 is marked other other traumetic event, II	17. Father's Name (First, Middle, Last) ERIC OSEI 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ad	18. Mother's Nar MAAME dress (Street and Number or Ru	_	S ty or Town, State, Zip Code)
(20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disposition cemetery, crematory	(Name of or other place)	Date 2007	Location - City or Town, State
Baltime permit. Page Department. Il Important: Il eny injury or	21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that cause	22. Nan	ne and Address of Eacility	er on in the	ZIIII Approximate
Physician /Medical	shock, or heart failure. List only one cause on each I timmediate Cause (Final disease or condition resulting in death)	line.		2781S	Interval Between Onset and Death
8760, example and the burial-transit and the	cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): BUE PLEW (s a consequence of):	ANCITY		28 days
Records, P.O. Box 6876(The law requires that the death certificate be tte has been signed by the attending physicia page 2 should be detached for use as the bur ompleted by Physician/Medical		2 Fetal death 3 Ector	oic pregnancy ir (specify)		23d. Date of delivery Month Day Year
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Vital Record ician: The law requir certificate has been s ector, page 2 should BE Completed	25. Was case referred-to medical			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
n of 'n of the ng Physical distribution on: To	examiner? 1 Yes 2 No Hospital: 1 ppati 27. Manner of Death 1 Matural 5 Pending (Month, Death Investigation)		DOA Other: 4 Nursing H	in the (Check only one) ome 5 Residence 28d. Describe how in	e 6 Other (Specify) njury occurred
	4 Homicide building, e	jury - At home, farm, street, fatc. (Specify)		City or Town, S	
o the Hosp thin 24 hou the Fune ompletely fil	29a. Certifier (Check only only) 2 ☐ Medical Examiner: On the basis of and manner st	of examination and/or investig	rred at the time, date and place ation, in my opinion, death occu 29c. License number	rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
	Maria O. Paul 30. Name and address of person who completed cause of	death (Item 23a) (Tune Prior)	D46156		1/27/07
State Registrar	GBMC NICH 6701 N. C.	NOVIES ST.	Baltimore, 1	nd 2120	24

			S State Amend #26 Per	tate of Maryl Phy G863	and / De 1/30 <i>[</i> 6	partment of H VirtiMate of L	ealth and M Death		ene g. No.2 A A 7	02344
			1. Decedent's Name (First, Middle, Last)					2. Date of Deatl	1	3. Time of Death
市	Physicia /Medic	_		len, Jr.				January		7:20 P ^M
	Examin	er	4a. Facility Name (If not institution, give street			4b. City, Town, or			4c. County of Dea	_
- De resign			5499 Sleeping Dog La 5. Social Security Number 6. Sex		yrs. last birthd	Columbi (ay) If Under 1 Year	if Under 24 Hrs.	8. Date of Birth	HOWa	
	Funeral Director		227-16-4196 ^{1⊠ M} Usual Residence of Decedent		83 Yrs	Months Davs	Hours Min.	Sept. 2	1,1923 Vi	thplace (State or Foreign ountry) rginia
	/land low at		10a. State 10b. County	10c	. City, Town o	r Location				10d. Inside City Limits
	a-fsh tifled	ctol	Maryland Howard			Columbia				1 □ Yes 2 🙀 No
	or 28	Director	10e. Street and Number			10f. Zip Code	4.5	10	og. Citizen of What Co	ountry?
	eath w	erai	5499 Sleeping Do	Mas Decedent Ever	in II S	210		ocify Ves or No.	U.S.A.	erican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married	Armed Forces? 1 1 1 Yes 2 No If Yes, Give Year or Dates:	11 0.3.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, Whi	
20	72 ho 'natur dical f	eted	15. Decedent's Education (Specify only highest grade co		16a. De	ecedent's Usual Occupa Give kind of work done of fe. DO NOT use retired	ntion Juring most of worki	ng	16b. Kind of Business	/Industry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use retired rtographer) -	I .	U.S. Gover	nment
р 5	filed Hygid Sther ent, th		17. Father's Name (First, Middle, Last)		, J.		18. Mother's Name			
Maryland	Alental Alental rked o	To Be	Robert Garner All	en, Sr.			Viola I	iee		
ary	2 shou and N is ma auma		19a. Informant's Name/Relationship (Type.	Print)		lailing Address (Street a			-	
رة ح	l and lealth m 27 her tr	9	Faye Allen (Wife)	120		99 Sleeping			bia, Maryl 20c. Location - City or	
Jore	ages 1 nt of h : If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem	oval from State		isposition (Name of crematory or other plac	1		,	
Baltimore,	nit. Pa artme ortani Injury	3	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	1411144	Metro (Crematory 22 Name and Addres Witzke Fu	1-30-		Catonsviii	e, Maryland
ä	Dep Imp any		Myns K. Had	cmo-		5555 Twin	Knolls I	nes, Inc Road Co	ĺumbia, MD	21045
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ons that caused the ause on each line.	death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	MYOCAR	DIAL	IMPARCI	Noi			Onset and Death Few Westy
	/Medical Examiner		resulting in death)	Due to (or as a cor						Leay
E _{qs.}		- L	Sequentially list conditions, b. —	Due to (ur es a cur	RECHEROLUS					July 1
۵-	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c							
o,	icate be executed physiclan and s the burial-transit	Еха	resulting in death) Last	Due to (or as a cor	nsequence of):	:				
8760,	ate be	d								
Box 6	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No	if yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
P.O.	hat the		9 ☐ Unknown Part II. Other significant conditions contrib	uting to death but no	t resulting in th	ne underlying cause give	en in Part I.	23e, Did tob	acco use contribute t	o the cause of death?
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900	law re	Completed	DEMENT'A					24a. Was ar autops		utopsy findings available completion of cause of
Ě	The rate has page	Com						perform	ned2 death?	
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O	Phys r this ral dir	1. To	I res ze No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpa	atient 3 DOA	4 12 Indrsing Ho		nce 6 Other (Sperwinjury occurred	ecify)
O	th. ; After	tion	1 V atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea		iry Worf	Yes 2 No		many occurred	
Division or Vital Records,	il or Atter after dea I Director d in by the	Certification:	· · · · C - C - · · · · ·	28e. Place of injury - building, etc. (S)	At home, farm pecify)	street, factory, office		28f. Location (St. City or Town	reet and Number or F , State)	ural Route Number,
	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one)							
	To t withi To t	Z	29b. Signature and title of certified	8		29c. Licenso	30469	1	9d. Date signed (Mon	9, 2007
	5+1		30. Name and address of person who comp N.B. VELLANK, 855	leted cause of death		(pe, Print) CARK	wat, +	3.8 C	o (cemb. n	Mg. 21045.
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	freet)				
	negisti	001	JAN 3 0 2007	Jan Bar Sand	15° 1	The state of the s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month :00 January Willie Mack Alston /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Hospital Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 □ F Days **Director** No, Carolina 231-14-5228 Usual Residence of Decedent 84 Oct 6, 1922 la or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1¥ Yes 2 □ No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21225 U.S.A. 901 Cherryhill Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1943 1 ☐ Yes 2 ☑ No þ Specify Black 3 Widowed 4 Divorced 1943 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -- Unknown Laborer MD Drydock Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angeline Hicks Willie Alston ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Cherryhill Road Baltimore, Maryland 21225 Pauline Alston Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/30/07 Crownsville, Md. rownsville Veterans Cemetery flure of Funeral Service Lic 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 11 Part1. En ar the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line nediate to use (Final asse or condition a. Approximate Interval Between Onset and Death Immediate or se (Final disease or Indition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner neum Dura Spivation Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Lue to (or as a consequence of) be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Hospital or Attending Physician: The law requires that the death certificate attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9□Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy Division or Vital 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 212 No မှ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 2

State Regist<u>rar</u> 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

The 301

32. Resistrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital Drive, Glen Burne, MD 21861

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22 2007 Month Ernest Brown Jr January 7:24 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Future Care Pineview Clinton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day) July 2 7. Age (In yrs. last birthday) Days Hours **1**√∑ M 2 □ F 1925 213-22-0121 81 July. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel 10e. Street and Number 1 ☐ Yes 2X No Lothian 10f. Zip Code 10g. Citizen of What Country? 4750 Sands Rd. 20711 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Truck Driver Md. State Highway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Brown Sr Lydia Keat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medagone. **Physician** /Medical

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Funeral

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Completed

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cal Certification: To

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

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funeral director, page 2 should

certificate |

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24 hours after death Funeral Director: filled in by the

within 2

completely

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

Marvin Brown(Son)

4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

CANCER CALCER

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01

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bladder with metastas

Win Name Releases of & acil Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death

20c. Location - City or Town, State

Baltimore, Md.

Due to (or as a consequence of) STOMach Due to (or as a consequence of) Due to (or as a consequence of)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

2 Accident

(Check only one)

29a. Certifier

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

24a. Was an autopsy rmed3 2 ☑ No 1□ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending investigation

and manner stated.

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

703 Newtown Dr. Apt H Annapolis, Md. 21401

1-30-07

3 ☐ Suicide 6 □ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ave, Suite 310 Washington, DC 20032

29b. Signature and title of certifier

29c. License number 51520

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 1-26-2007

30. Name and address of person who comple d cause of death (Item 23a) (Type, Print) 1328

Pishdad Bahram 31. Date filed (Month, Day, Year)

Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

		-	1- For State Of Mary Registrar		rtificate of Dea			ene g. No. 2007	023	147
1	Physicia	ın	1. Decedent's Name (First, Middle, Last)		8	-	Date of Death Month	Day Year	3. Time of D	
	/Medic	- 6	3e55E 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		annary	26, 200 1 4c. County of Deat		1
	Examin		Jours Hopkins HOSPITAL		BALTLINOR					
-21-0	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1440 92 5112 1440 92 5112 1440 92 5112 153	'n yrs. last birthday) Yrs.	If Under 1 Year If U	Under 24 Hrs. 8.	Date of Birth (Month, Day, ept 18,	Year) Co	nplace (State or F untry) th Caro	_
	w		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc	cation				10d. Inside City	Limits
	Maryla a-f shor	ţo	Maryland St. Mary's		icsville				1 □ Yes 2	
	th the or 28a e noti	Sirec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	•	
	ath wi	ral	30105 Moccasin Court		20659			United Sta		
220	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 □ No PitYes, Give Year or Dates:	Active Duty	Nas Decedent of Hispar f Yes, specify Cuban, M l □ Yes 2∏No Sp	inic Ongin? (Specit Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify: White	e, etc.	
5	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during DO NOT use retired)	n na most of workina	1	6b. Kind of Business/	industry	
7	vithin ne.	m pla	Elementary/Secondary (0-12) College (1-4or 5+)	1	OO NOT use retired)	3		II C. A.		
7	filed v Hygie ther t	ပ္ပိ	12 17. Father's Name (<i>First, Middle, Last</i>)	Msgt	18.	. Mother's Name (F	First, Middle, N	U.S. At	rrorce	
0	lid be ked o	To Be	Samuel Cass Birchfield			Della	P. Hal	11		
<u>a</u>	should and Men s marke tumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and I	Number or Rural F	Route Number,	City or Town, State, 2	Zip Code)	
, A	and 2 ealth a n 27 is ner trai		Teresa Birchfield (wife)	3010	5 Moccasin	Court, M	echanio			
2	ges 1 if of H if iter or oth		20a. Method of Disposition ∭Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify)		sition (Name of matory or other place)		- 1	20c. Location - City or		
Daltillo	it. Pa intmen intant: njury		4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee	North Co	ve Church C	Cemetery		Marion, Non	th Caro	lina
Ö	permit. Pages 1 and Department of Healt Important: if Item 2' any Injury or other once.		Cynatica 1 These Mo 144		2. Name and Address of lexandria F				0633 O1d 20735	
	*		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying, su	uch as cardiac or i	espiratory arre	est,	Approximate Interval Between	een
	Physician	9	Immediate Cause (Final disease or condition resulting in death)	ic paner	entre an	ur			Onset and De	
	/Medical Examiner		Due to (or as a co							
L	a) or	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	consequence of):						
	cuted nd ransit	Examiner	that initiated events C.							
o O	tificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last Due to (or as a co	onsequence of):				1		
00/00		edical	d							
O. Box	ding Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 10 ☐ Yes 2 ☐ No 9 ☐ Unknown	☐Fetal death 3☐	Ectopic pregnancy Other (specify)			23d. Date of del Month		ear
ras, r	quires that in signed b uld be deta	ρ	Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause given in	n Part I.	23e. Did tob	es 2 No 3 □ Pr	o the cause of de obably 4 □Ur	
II Records	The law reate has been	Completed					24a. Was ar autops perforn 1 Yes	y prior to	itopsy findings a completion of cau	vailable use of
V II al	ician: sertific ector,	Be (25. Was case referred to medical examiner?			6. Place of Death (Check only on	9)		
0	Physic this cral dire	٦.	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatien				nce 6 Other (Spe	cify)	
UO.	Attending Physician: r death. ector. After this certific by the funeral director,	tion	1 Natural 5 Pending (Month, Day Y		Work?	s 2 □ No	u. Describe no	w injury occurred		
INISION		Certification:	a David Could not be	r - At home, farm, str (Specify)	reet, factory, office	28	f. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Numb	ier,
	spital or cours afte neral Dir filled in		29a. Certifier 1 Certifying Physician: To the best of r	my knowledge, deat	h occurred at the time, o	date and place, an	d due to the ca	ause(s) and manner as	s stated.	
	To the Hos within 24 h To the Fur completely	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner states	xamination and/or in d.						
	with To	Σ	29b. Signature and title of certifier		29c. License nu	umber	2	9d. Date signed (Mont	h, Day, Year)	
(4		TEUW WW MD, PHD	th (Itom ODa) (Tim	Reint)	- 000		JANUARY 7	-6, 200	7-
	10		30. Name and address of person who completed callies of deat EDW W BSTRIN WD PHD SONA	WY HAPY	NS HASPITE	A1 - 600	NOOTL	MAILES	TREET	
J	Sta		31. Date filed (Month, Day, Year) JAN 3 0 2007 32 legistrar's	s Signature	Print) AS HOSPITA	VI 10-0	B	ALTIMORE	, MD 21	287
	Regist	rar	JAN 3 U ZUU/	1 10 19					i	

Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

Physician

*/Medical

Examiner

Funeral

Director

28a-f show

al Hygiene.

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic ever once. 2 19a. Informant's Name/Relationship (Type. Print) Mark Beauchamp -20a. Method of Disposition 21. Signature of F 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Physician/Medical IF FEMALE: 23b. Was decedent pregnant ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed has certificate 25. Was case referred to medical examiner? Be Hospital: Other: 2 10 1 Dinpatient မှ 1 Tyes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print). A MAY B. KANEUR 349 1 349 Malcolm dure, wentminsty

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

JAN 3 0 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26 Day Physician 2007 1:00P M Jan. Joseph Benedict, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1√2 M 2□ F 69 Yrs 24 1937 218-34-1810 Nov. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Owings Mills MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21117 122 Cedarmere Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 【 No Specify: white Baltimore, Maryland 21215-0036 Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cosmetic Co. Electrician 11 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Cook Joseph Benedict, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 122 Cedarmere Rd., Owings Mills, MD 21117 Peggy A. Benedict/wife Department of Healt Important: If Item 2 any Injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 1/27/07 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Funeral Service 10 W. Padonia Rd., Timonium, MD 21093 Flagle 23a. P. T. Enter the dise shock, or heart failure. List Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** youtus omplications disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, issuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a nonsequence off Examiner resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence (Specify) WS PCG 1 ☐ Yes 🛕 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

15

within 24 hours a

To the Funeral E

completely filled i

Medical

29a. Certifier

29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) JAN 3 0 2007



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number \$8303

29d. Date signed (Month, Day, Year)

"N. Charles St Brenne us way

DHMH 17 Rev 1/2001

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State Registrar OLD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

+COSPITAL 5401

32. Registrar's Signature

NORTHWEST

31. Date filed (Month, Day, Year)

TODOR

ROXD

RANDALLSTOUIN MD 21133

MIRCEA

COURT

			For State Registrar	State of Ma	aryland		artmen <i>tificat</i>			and M		giene Reg. No.	2007	02351	
П	Physicia	20	1. Decedent's Name (First, Middle, L.	ast)							2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic		Frederick E. Br								Januar	y 28			
	Examin	ner	4a. Facility Name (If not institution, gi Sinai Hospital				В	altir	73					I/A	
	Funeral Director			Sex 7. Age		6 Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da July 7,	th y, Year) 195		inthplace (State or Foreign Country) Iryland	,
	death with the Maryland ms 23a or 28a-f ehow Frount be notified at	tor	10a. State 10b. County	I/A	10c. City	, Town or Lo		alti	nore					10d. Inside City Limits XX Yes 2 □ No	
3	n with the 23s or 28s	Funeral Director	10e. Street and Number 836 W. 36th Stree	et.			10f. Zip	Code		2121	1	10g. Citi:	en of What C	Country? USA	
020	n 72 hours after death with the Marylan "naturel", or Items 23a or 28a-f ehow edical Exercit ar Louist ke notified at	by	11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes XXI If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 🗆 Yes		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.))	4. Race - An Black, Wh Specify:	nerican Indian, lite, etc. White	
1213-003		Completed	15. Decedent's Elementary/Secondary (0-12)		i+)	16a. Deced (Give life.	kind of wo	al Occupa ink done o se retired, ntena	luring mos	t of worki	ng	16b. Kii	Maint	s/Industry enance	
ם ש	be tiled ital Hygi id other event, I	To Be Co	unknown 17. Father's Name (First, Middle, Las Bernard Briggerma	•					18. Mothe	_	(First, Middle, es Nash				
<u>a</u>	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship								I Route Numb				
≥ o`	l and lealth m 27 her tr		Annie Nash	Sister	20h BI	3730 ace of Dispo	Elm .		ıe		ltimore	-			_
	82=5		20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3		Ce	metery, crer	natory or o	ther place		/1/2				or Town, State	
	iit. Pa artmen ortant: injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service/Lice		Oak	lawn (2. Name ar				007	рати	more,	Maryland	_
n D	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		1	Charles		Bi	irgee	-Hens	ss-Se	itz	Funeral Itimore	Hom	e, Inc		
			23a. Int. Enter the discare, or cor	mplications that caused	the death	. Do not ent	er the mod	alls le of dying	ROAG g, such as	cardiac o	r respiratory a	rrest,	_21211	Approximate	
	hysician		shock, or heart failure. List onf Immediate Cause (Final	y one caust on each li]e.		1-	U						Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ience of):	Wir	yr~	ma						
	Examiner		Sequentially list conditions	b	Du	muk	ali	m							
	o .≡	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	c ce of):									
× :	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dun to (or so											_
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287	certificate be executed ding physicien and use as the burial-transit	edical		d						·					-
ğ	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3[Ectopic p Other (sp					2	3d. Date of d Month	elivery Day Year	
7	res thet tl igned by be detac		Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the u	nderlying o	ause give	n in Part I		23e. Did t	obacco u	se contribute	to the cause of death?	
SD	uires sign Id be	d by	metastatic C	arcinoma		uman		nha	own		1 🗆	Yes 2]No 3 □ I	Probably 4,2Unknown	E
cord	The law requires thet ste has been signed b page 2 should be deta	Completed					ð				24a. Was	an	24b. Were	autopsy findings available	-
E E	The lav	E										ormed?_	prior to death?	completion of cause of	
		Be C	25. Was case referred to medical						26. Place	of Death	1 Tes		10.11	es 2 No	
5	S S	70	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2,21	ER/Outpatier	nt 3 🗆 DC	Othe Othe	er: 4 □ Nu	ursing Hor	me 5 ☐ Resi	dence (Other (Sp	pecify)	
	ding Ph h. After th funeral	on:	27. Manner ol Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury		28c. Injury Work			28d. Describe	how injur	occurred .		
<u>s</u>	eat or:	cat	2 Accident investigati 3 Suicide 6 Could not	be -	A . b .		М		/es 2 □		204 1	·C44	1.51	0 -10 - 1	_
=	i Diff	Certification:	4 Homicide determine	building, et							City or To	wn, State,		Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral (completely filled	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the best aminer: On the basis o and manner st	f examinat	wlodgia Jose ion and/or in	h senimed vestigation	at the tim , in my or	ia data an pinion, dea	id plane ith occurr	and due to the ed at the time,	date and	and manuer place, and d	pue to the cause(s)	
	vithin 2 To the comple	Me	29b. Signature and title of certifier	and manner su	ateu.		29	c. License	number			29d. Dat	signed (Mo	nth, Day, Year)	
)	->F0		I amount	1011.				D	002	173	, 0	1-	- 28.	-07	
	3			o completed cause of c	leath (Item	23а) (Туре,	Print)		a.	10 5	RIL		_ ^	ND 21209	-
			31. Date filed (Month, Day, Year)	tel 240			طال	der	د در		المه	mo	٥, ١	1209	_
	Sta Registi	ate rar	JAN 3 0 20	07 Section	ar a dignal	GOS.	es.								

Pt Known to Briagerman, Frederick

			For State Registrar	State of Mary		artment of rtificate of			giene	07 02352
H	Physicia		1. Decedent's Name (First, Middle, Las	"th				2. Date of De Month	Day	Year 3. Time of Death
ė.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D	peathy	4c. County	of Death
				g Hone		Manche If Under 1 Year		Hrs. O. Data of Bir	Car	
	Funeral Director		5. Social Security Number 6. Sec. 1140/6994	M 200 F 90	yrs. last birthday) Yrs.	Months Days		Hrs. 8. Date of Bir (Month, Da 7-20-1	y, Year)	9. Birthplace (State or Foreign Country) Maryland
and	A		Usuat Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
Mary	fled	tor	MD Carroll	County	Hamp	stead				1 ☐ Yes 2 /∑X No
:1215-0036 within 72 hours after deeth with the Maryland	ital Hygiene. od othar than "naturel", or iteme 23a or 28a-f ehow event, Ita Madical Examinar must be notified at	Funeral Director	10e. Street and Number 1200 Woodland Co	ourt		10f. Zip Code	21	074	10g. Citizen of	What Country? USA
r deeth	teme 23	Inera	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cul		? (Specify Yes or No uerto Rican, etc.)	- 14. Rad Bla	ce - American Indian, ck, White, etc.
5-0036	el, or it Examin	۾	1 ☐ Never Married 2 ☐ Married 3 ☑ Vidowed 4 ☐ Divorced	1 ∐Yes 2 XX No tf Yes, Give Year or Dates:		1 ☐ Yes 2/CXNo			Specif	y: white
5-0 22 Pe	natur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usuat Dccu kind of work done DO NOT use retire	pation during most of	working	16b. Kind of B	usiness/Industry
2121 d within	giene. er then the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		fice wor			Stieff	Silver Company
8	Mental Hygi erked other atic event, 1	Be	17. Father's Name (First, Middle, Last) John Thalwitzer	Hutchins				Name (First, Middle, Grace Mar.	_	
ary shouls	2 5 5	ဥ	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Stree	t and Number o	r Rural Route Numb	er, City or Town,	, State, Zip Code)
, M	ealth ar n 27 is ner treu		Janice D. Donohu					Hampste		21074
more	or off		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐	Heilioval Itolii State	Ob. Place of Dispo cemetery, crea Lorraine			Date 1 / 26 / 0.7		- City or Town, State ore, Maryland
altimore,	Department of Heal Important: if item 2 any injury or other once.		4 Donation 5 Other (Specify 21. Signature Funeral Sergice Light		2:	Name and Addr	ess of Facility			
60 8	22 = 8		23a. Part1. Enter the disease, or comp	Pulle				tz Funera Baltimore		Land 21211 Approximate
^ PI	nysician		shock, or heart fallure. List only of the timediate Cause (Final disease or condition	one cause on each tine.	Coath. Do not on	an the mode of dy	ing, such as car	diac of respiratory a	11031,	tnterval Between Onset and Death
	Medical xaminer		resulting in death)	a. Due to (or as a co	nsequence of):	~	11.1	hurhock	2	- June
	s1/ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	inseq (ince of):	mmay	Jourse	melwer	record	209-
xecuted	al-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):					
8760 ate be e	hysicien and the burial-transit	cal	(d						
Box 6	nding ph use as t	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Da	ate of detivery
O. Teges	ed by the attending p	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown		Ectopic pregnand Other (specify)	cy 		Mo	onth Day Year
s that if	igned by be detac	by Ph	Part II. Dther significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use con	tribute to the cause of death?
ord:	been sig should b							_ 10'	Yes 2□No	3 Probably 4 □Unknown
VISION Of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed	te has b age 2 si	Completed							rmed?	Were autopsy findings available prior to completion of cause of death?
E E	certificete rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes Death (Check only of		1 ☐ Yes 2 ☐ No
of V	this canding	၉	1 Yes 2 No 27. Manner of Death		2 ER/Outpatier	IT 3L DOA		ng Home 5 Resi		
o all	sr death. •ctor: After this certificete haby the funeral director, page	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) Injury	W	ork? ☐Yes 2☐No	28d. Describe	how injury occur	red
÷ 5	after de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office)	28f. Location (City or To		ber or Rural Route Number,
To the Hospitei	within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of miner: On the basis of exa	y knowledge, deat	h occurred at the	time, date and p	lace, and due to the	cause(s) and made	anner as stated.
the the	ithin 2.	Medical	one) 29b. Signat⊮le and title of certifier	and manner stated.			ise number			ed (Month, Day, Year)
	· s ⊢ ŏ		John W. J	middle	r Name	22	5443			•
	4		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) D	11.15	1 1		02/157
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	J P C	, WAS	mys /2	7	V 7/13/
1	Registr	rar	Calle							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 02353 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RICHARD BAYLY BUCK P MJanuary 27, 2007 4:00 */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days 212-20-2507 1**X** M 2□ F 85 8/7/1921 Director MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. MD BALTIMORE LUTHERVILLE 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 11219 GREENSPRING AVENUE 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Y☐ Yes 2☐ No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2X Married timore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) EXECUTIVE DIRECTOR NURSING HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE BUCK JULIA BLUNT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. BAYLY BUCK son 12722 LONG GREEN PIKE, HYDES, MD 21082 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State GREEN MOUNT 1/30/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ZMS /Medical Examiner Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as use IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. the 9□Unknown 9 DUnknown has been signed by le 2 should be detact Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Coloths 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perforn certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA spital or Attending Pinous after death.
Ineral Director: After the filled in by the funeral 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) edellw completed cause of death (Item 23a) (Type, Print) LEH ALT, III NO. 6301 N Charles Street Baltmore, ND 21212 IGLEH ALT

Registrar

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2007

7-00687		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene									
had Brown		1- For State Certificat	nt of Health ar e of Death	nd Mental H	, 0	200	7 0005				
Physici		Decedent's Name (First, Middle, Last)			2. Date of Deat		3. Time of Death				
Medical Exami	ner	CHAD CHRISTOPHE 4a. Facility Name (if not institution, give street and number)		or Location of Death	Month January 24	4, 2007 4c. County of Dea	1650 hrs				
)		72 S. Carrollton Ave	Baltimore			City					
Funeral Director		5 Social Security Number 6 Sex 7. Age (In yrs. last birthd 216-11-5898 1X M 2 F 29	Months Da			(1077 Fore	non				
		216-11-5898 1XM 2 F 29 Usual Residence of Decedent	Yrs.		p3/10/	(1311)	Country) MD				
ом апу		10a State 10b. County 10c. City, Town or					10d Inside City Limits				
daryland 28a-f show any <u>1 at once.</u>	Director	MD CITY BALT 10e. Street and Number	IMORE 10f. Zip Code		10	Og Citizen of What Co	1 Yes 2 No				
ith the Maryland 23a or 28a-f sho notified at once.		72 S. CARROLLTON AVE.	2122	3		USA					
ath with	uneral	1 X Never Married 2 Married Armed Forces?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc	erican Indian, Black,				
after de al", or ner mu	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 Yes 2 X N	o specify:		Specify: W.H.	IITE				
hours "natur		 Decedent's Education (Specify only highest grade completed) 16a. De 	cedent's Usual Occupa ring most of working life			16b. Kind of Busines	s/Industry				
5-0036 led within 72 Hygiene. other than the Medical	ompleted		CTRICANS	HELPER		CONSTRUC	TION				
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner.	ပ	17. Father's Name (First, Middle, Last) FRANCIS WAYNE BROWN		18 Mother's Name							
(= = 5	To Be						te, Zip Code 2 1 1 3 6				
MD and 2 sho salth and em 27 is raumati			05 PLEASA Disposition (Name of ce		NS DR.		STOWN, MD				
Baltimore, Dermit Pages I at Department of He, Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory	or other place)			20c Location - City of					
Baltin permit P Departme Importan injury or		4 Donation 5 Other Specify ALL COU 21. Signature of Service Licensee	22 Name and Addres	SS of Facility FT.	TZ9/U/	EUNEBAT.	HOME DA				
		254 E. MAIN ST., WESTMINSTER, MD									
Physician /Medical		fallure List only one cause on each line. Immediate Cause (Final disease a. Cardiac arrhythmia	The the mode of dying	g, such as cardiac o	r respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a consequence of):									
	ner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause									
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executed an and al - transit	ical E	MENDED AMENDED NO. 005 0									
60, ate be e shysicia	Medi	#23a,2/,penVIE, g805,	3/20/07 TT			23d. Date of delive	rv				
Sox 68760, leath certificate be of a attending physicia for use as the buria	sician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3	Ectopic pregna	ncy	Month	Day Year				
Box ne death the atte	Physi	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			3					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ρ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	given in Part I.		bacco use contribute t	o the cause of death? Obably 4 Unknown				
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Recc The lav icate has	Somp				perform	med? death?					
Vital Reo ysician: The his certificate director, page	Be	25 Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outp.	26.Plac	Other							
n of V ling Phy After th funeral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim				Residence 6 Oth	er. Scene				
Sion Attendi death ector:	catio	Pending 2 Accident Investigation		Yes 2 No							
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	, street, factory, office	building, etc.	28f. Location (S or Town, St		tural Route Number, City				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death									
To the within to the comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or inverse and manner stated. 29b/signature and title of certifier	estigation, in my opinion		t the time, date a	and place, and due to to 29d. Date signed (M					
		(Xelohema)	i	.M.E.		January 25, 200					
		30. Name and address of person who are leted cause of death (Item 23a)	Conn Ctract Dall	mara MD 040	04						
St	ate	31 Date filed (Month Day Year) 32 Pristrate Signature	Penn Street, Balti	more, MD 2120	J1						
Regist		JAN 3 0 2007	9000								

			For	State of Marylan					jiene	
			For State Registrar		Cer	tificate of	Death		leg. No 2 0 0 7	02355
	Physici		1. Decedent's Name (First, Middle, Last) Robert	L. Bingham				2. Date of Dea Month January	Day Your	3. Time of Death 1:10 A M
	/Medic		4a. Facility Name (If not institution, give str			4b. City, Town, or	r Location of Dea		4c. County of Dea	
			1057 Hillside Lake			Gaither			Montgomer	У
19.5	Funeral Director		031-20-0207	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day Sept. 1	9. Bir Co 3, 1930 Ho]	thplace (State or Foreign untry) 1and
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Man la-f sh tified	ctor	Maryland Montgomer	y Gai	ithersl	ourg				1 ves 2 No
	with the	Funeral Director	10e. Street and Number 1057 Hillside Lake	Terrace		10f. Zip Code 20878			log. Citizen of What Co	
	death ms 23	nera		. Was Decedent Ever in U.	S. 13. V		ispanic Origin? (S	Specify Yes or No- rto Rican, etc.)	Jnited Stat	rican Indian,
õ	after or ite	y Fui	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		f Yes, specify Cuba ☐ Yes 21 No		rto Rican, etc.)	Black, Whit	
Š	hours tural"; al Exa	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates:		ent's Usual Occup				
21215-0036	hin 72 9. In "na Medic	Be Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of work done of NOT use retired	during most of wo f)	nrking	16b. Kind of Business/	Industry
7	ed with	Com		5-1-	Nucle	ar Physic			US Governm	ent
yland	d be fil antal H red oth	Be c	17. Father's Name (First, Middle, Last) David Bingham				18. Mother's Na	me (First, Middle, i	Maiden Surname) Cate	
ary	should and Me s mark umation	То	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a		22.0	r, City or Town, State, 2	Zip Code)
, Mar	and 2 ealth a m 27 is		Valerie M. Bingham/						ithersburg	, MD 20878
saitimore,	Pages 1 nent of H nt: If Ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place Crematorium	4	ary 29,	20c. Location - City or Bethesda, M	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ligensee	len M00092	Roc Roc	Name and Addres			umphrey FU	neral Home venue
Ki Kir			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death	. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between
Š.	Physician		Immediate Cause (Final disease or condition resulting in death) a.	Respirator						Onset and Death 2 weeks
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	w requires that the death certifica been signed by the attending ph should be detached for use as the	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)			Month	Day Year
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Sion or	ding Physician: The law h. After this certificate has funeral director, page 2 '	-	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ow injury occurred	ary)
N S	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	e Could not be	28e. Place of injury - At hor building, etc. (Specify	me, farm, stre		2010	28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	ne Hospit n 24 hours ne Funera pletely fille	Medical C	29a. Certifier 1 ☐ Certifying Physic (Check only one)	ian: To the best of my known: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	withi To th	Ň	29b. Signature and title of certifier	E/100	~/	29c. License MD 560			9d. Date signed (Month	
	16		30. Name and address of person who comp	ol led cause of death (Item		Prin				
) Sta		Carlos E. Picone, M. 31. Date filed (Month, Day, Year)	D., 5530 Wis	ure		#930, Ch	evy Chase	e, Maryland	20815
	Registr		JAN 3 0 2007	Bour &	A Soul	us)				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** MARYANN BUTLER Many 10 ,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Commons Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2(XF Yrs. Director 78 219-30**-**6996 June 12, 1928 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 N. Rolling Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Exercities. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No ۵ Specify: 3 ☐ Widowed 4 N Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 healthcare 4 nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Thomas Hood Nellie Virginia Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Chantilla Road Catonsville, MD 21228 James L. Butler/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ^¹ 4 XDonation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Part | Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 1 west /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ ¥6 Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Donknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred of medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Laursing Home 5 Residence 6 Other (Specify) 2 1 Tes 25 No 2 ER/Outpatient 3 DOA this (27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending death. investigation 1 Tyes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 24, 2007 d address of person who completed cause of death (Item 23a) (Type, Print) Rd. Cataryille TURAKINIA Frederick 1009 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 3 0 2007

07-00573

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Gary Mitchell Coope	J	tate of Maryland / De	-		d Mental I	Hygiene	9.2.0.			
	1- For State Registrar		Certificate of	Death			eg. No. 200	7 0225		
Physician/ Medical Examiner	Decedent's Name (First, Midd					2. Date of Dea Month	Day Year	6. Time of Death 0545 hrs		
January 1	4a. Facility Name (if not instituti	MITCHELL C	ooper.	b. City, Town, or	Location of Dea	January 2	1, 2007 4c. County of Deat	1		
	Frederick Memorial F	ospital		Frederick			Frederick			
Funeral	5. Social Security Number	6. Sex 7. Age (In yr	rs. last birthday)	If Under 1 Yea		_	rth(MM/DD/YYYY) 9. Bi			
Director	UNK	1 M 2 F 54	Yrs	Months Day:	s Hours Mi	n. August	15, 1952 Forei	ountry) MD		
any	Usual Residence of Decedent 10a. State 10b. County	110c (City, Town or Locati	on				10d Inside City Land		
* .		. /	(1) itm					10d Inside City Limits 1 Yes 2 No		
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vith the Maryland s 23a or 28a-f show a contifted at once.	9095 Tilah	00		21	676		(15)			
ms 23; be not	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. Wa	Decedent of His	panic Origin? (Specify Yes or No	14. Race - Amer	ican Indian, Black,		
or items 23: must be no	1 Never Married 2 N	larried Armed Forces?	0	es, specify Cuban	-	o Rican, etc.)	White, etc.			
s after ral", niner		vorced If Yes, Give Year or Dates:		Yes 2 No				ack		
OO36 I within 72 hour giene her than "natu E. Medical Exar	Elementary/Secondary (0-12)	College (1-4 or 5+)		t's Usual Occupat ost of working life.			16b. Kind of Business/	Industry		
)36 thin 7, than than edical		4		ATT	Tech	1	(A too mo	unscation		
5-0036 Led within 7 Hygiene other than the Medica	17. Father's Name (First, Middle	, Last)		/ 			Maiden Surname)	07010001		
121 l be fill ental l arked vent,	Carlton	G. Cooper			Flo	rence	B - Co ch	rei		
nore, MD 21215-0036 ***ages I and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene tt: If item 27 is marked other than "natural", or items 23a or 28a-f she other transmatic event, the Medical Examiner mast be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relation	/								
and 2 sho lealth and tem 27 is transmati	Hovence B. Co 20a. Method of Disposition	open/ nother	Db. Place of Disposi	5 Ti/g	hman 18	ω ω ,	Hman, Ml 20c. Location - City or	7 2/6/6		
MOFe, Pages I are tent of He ant: If ite	1 Burial 2 Crematio		crematory or oth	er place)						
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Balti permit Departu Import injury (1			Haw P	Rolando	Roal.	Baltmine Baltmine	MNZVZNI		
Physician	23a. Part I. Enter the disease, o failure List only one cause	complications that caused the dea	ath. Do not enter th	e mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval		
/Medical / Txaminer	Immediate Cause (Final disease	Casaina interi	cation					Between Onset and Death		
	or condition resulting in death)	Due to (or as a consequence	e of):							
le le	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause Enter Underlying Cause									
led nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C								
eve an al-	X UNPENDED	X AMENDED TH, 23a	27 DTT 27	282-f re	~MF ~96/	2/9/07 7				
	IF FEMALE:	23c. If yes, outcome of pr	regnancy	,20a-1, pe	errae, good	2/0/0/	23d. Date of deliver	<u> </u>		
Box 68760 he death certificate the attending physited for use as the b	23b. Was decedent pregnant in t past 12 months?	Live birth Live birth Pregnant at time of	f doath	al death 3	Ectopic pregn	ancy	Month [Day Year		
Box e death the atte ed for u	1 Yes 2 No 9 Un	known 9 Unknown	odeath 5 Oth	er (Specify)				i		
P.O. I as that the gened by the detached by by by by the detached by the detached by the detached by the by the by by the by	Part II. Other significant condi	tions contributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.	23e. Did to	obacco use contribute to	the cause of death?		
s, P.O. irres that the signed by to doe detach	Atheroscleroti	c cardiovascular dis	sease			1 Yes	s 2 🗸 No 3 Prot	pably 4 Unknown		
Division of Vital Records, tal or Attending Physician: The law require res after death and Director. After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed						24a. Was a autop		topsy findings available completion of cause of		
Reco							med? death?			
cian:	25. Was case referred to medica examiner?	-	·		of Death (Check	only one)				
of Viring Physical After this funeral dir.	1 Yes 2 No 27. Manner of Death		✓ ER/Outpatient				Residence 6 Other			
n of Nading Physics After the funeral	1 Natural 5 Pen	28a Date of Injury (Month, Day, Year)	28b. Time of Ir	400	y at Work? 'es 2 X No		now injury occurred			
isior Attender death rector: by the	2 Accident Inve	stigation FIII 1/21/2007		alli I		unknown	Street and Number or Ru	ral Poute Number, City		
Division o Hospital or Attending 44 hours after death Funeral Director: Aft felled in by the fune	3 Suicide 6 X Cou	rmined (Specify) found (-			tate) Th St. Frederic			
	20a Codifier	hysician: To the best of my knowl	ledge, death occurr	ed at the time, da	te and place, an					
To the Howithin 24 Properties Completely		miner: On the basis of examination and manner stated	n and/or investigati	on, in my opinion,	death occurred	at the time, date a	and place, and due to th	e cause(s)		
Σ	29b. Signature and title of certifi			29c. License			29d. Date signed (Moi	nth, Day, Year)		
T	my n	j, m.D		0.C.N	/I.Ε.		January 22, 2007	7		
3		who completed cause of death (It int Medical Examiner 11		Baltimore #	MD 21201					
State										
Registrar	JAN 3 0 20	07 Brown &	prode							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Roxanne Sue Cougle 28, 2007 4:00 P M January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2078 Rockrose Avenue Baltimore N/A/5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 212-88-4902 36 Balto, Oct 5, 1970 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore 1XXes 2 □ No N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 2078 Rockrose Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married XX Married

1 ☐ Yes 2 📉 💢 o

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory

23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Bram

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Specify.

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

1/31/2007

z Funeral Balto, MD

2078 Rockrose Avenue Balto, MD 21211

Estella M. Deal (nee Hubbs)

(Give kind of work done during most of working life. DO NOT use retired)

Certified Medical Assistant

22. Name and Address of Facility Burgee—Henss—Sei 3631 Falls Road

3 □ Ectopic pregnancy

5 ☐ Other (specify)

Specify: White

16b. Kind of Business/Industry

Johns Hopkins

20c. Location - City or Town, State

23d. Date of delivery

Day

Jome of

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Approximate Interval Between Onset and Death

Year

Catonsville, MD

Physician /Medical Examiner

injury or other permit. Pages 1 an Department of Heal Important: If Item 2

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

MD

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

IF FEMALE:

17. Father's Name (First, Middle, Last)

15. Decedent's Education (Specify only highest grade completed)

David Allen Gatewood, SR.

Mr. Donald B. Cougle (husband)

3 □Removal from State

19a. Informant's Name/Relationship (Type. Print)

1 ☐ Burial 2 ☐ remation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Fuheral Servic ice e

College (1-4or 5+)

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed vent of Health and Mental Hygis int: If Item 27 is marked other

attending physician and for use as the himself the cate has been signed by page 2 should be detach this

Division or Vital Records, P.O. Box 68760, after death Director: filled in by the

Examiner The law requires that the death certificate be executed Physician/Medical þ Hospital or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Elizabeth Connelly 2007 January 11:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 5, 1924 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. New York 374-20-6475 1 ☐ M 2 💢 F 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☐ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Kenwood Avenue 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse **Healthcare** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick Ryan Anne Maria Clego 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Azure Sellers - Granddaughter 1232 Pease Court, Alameda, CA 94501 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD Veter, cicethe retherplace) Burial 2 Cremation 3 Removal from State 1-26-2007 Crownsville, MD 4 □ Donation 5 □ Other (Specify) Crownsville ine of Euneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC ADENOCARCINOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1□ Yes 2∏ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Tes 2X No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

signed by the attending physician and the detached for use as the burlal-transit Vital Records, P.O. the funeral director.

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Exa⊡lner must be notified at

item 27 is marked other than "natu other traumatic event, the Medical

Physician

/Medical

Examine

Examiner

Maryland

Baltimore,

Director

Funeral

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Completed

death with the Maryland

Physician/Medical Completed by Be ဥ Certification: Medical

State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

JAN 3 0 200

29b. Signature and title of certifier

(Check only one)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

32 Registrar's Signature

DHMH 17 Rev 1/2001

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

			1- For State Registrar	ate of Maryland /	Department of Certificate of				02360
			Decedent's Name (First, Middle, Last)		- Cortinidate o	, Douth	2. Date of Death	g. No.	3. Time of Death
	Physicia /Medic		RICHARD I	ERNEST	COOPE,	R	Month /	28 200	7 2:50P.M
	Examin	er	4a. Facility Name (If not institution, give street	1/	4b. City, Town	, or Location of Death	200	4c. County of Death	10.
	Funeral		5. Social Security Number 6. Sex	THIE HOSPIC	oirthday) If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth	9 Birth	place (State or Foreign
Н	Funeral Director		219-52-6133 IXM		Yrs. Months Day	rs Hours Min.	(Month, Day,)	1951 MA	RULAND
	pur *		Usual Residence of Decedent 10a. State 10b. County	10e City To	wn or Location		/		10d. Inside City Limits
	Maryla	ō	MARILLAMA 11/A	100. Sky, 10	BI	LITIMO	DE 11.7	7/	Yes 2 No
	r 28a-	Director	10e. Street and Number		10f. Zip Code	FLIIMOR		g. Citizen of What Co	intry?
	th with	aiD	511 NORTH FULT	ON AVE. APT	#2	21217	7	USA.	
	er dea	Funeral	A	as Decedent Ever in U.S.	13. Was Decedent of If Yes, specify C	f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	hours after death with the Maryland ural', or Items 23e or 28e-f show al Examiner must be nutified at	by F	If	☐ Yes 2 Ž No Yes, Give ear or Dates:	1□Yes 2ŽÍN	lo Specify:		Specify:	MU
21215-0036	72 hou natura		15. Decedent's Education	16	a. Decedent's Usual Occ	upation	. 10	6b. Kind of Business/I	ndustry
218	within 7 iene.	Completed	(Specify only highest grade com Elementary/Secondary (0-12) C	ollege (1-4or 5+)		ne during most of work ired)			0
	filed w Hygier other th		8 THGRADE 17. Father's Name (First, Middle, Last)		UANIT	1	(First, Middle, Ma	PT. MANAG	EMENT CO.
auc	id be f ental } ked oi c eve	To Be	FRNFST B	. HAU	IKIAK	O P	A (First, Middle, Mi	Alderi Sulliame)	SER
Maryland	2 should and Men is marke eumatic	H	19a. Informant's Name/Relationship (Type, P		b. Mailing Address (Stre	et and Number or Run	al Route Number, (City or Town, State, Z	p Code)
_	and 2 ealth a n 27 ls		DAISY CLOPER	(WIFE)		ILTON AVE	E. APT &	BALTO, M	P. 21217
ore	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other treumatic event, the Madical Examinat must be millised at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	comot	of Disposition (Name of ery, crematory or other p	lace)	Date 20	Oc. Location - City or 1	own, State
Baltimore	Pa First		4 Donation 5 Other (Specify) 21. Signatur of Funeral Service (Specify)	O MT. Z	ZION CEME		01-011	ANSDOWN	E, MD
Ba	permit. Departr Imports any Inju		Macaulia Solution	6. Land	22. Name and Add	PH H. K	ROWN	JK. FUNER BAITO, ML	AL HOME. 21217
			23a Part1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death. Do	not enter the mode of d	ying, such as cardiac	or respiratory/arres		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	on-small cell	lune carre	· e /			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):				1 50.0.0
		- e	Sequentially list conditions, b. —	Due to (or as a consequence	e of):				
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9 X	The law requires that the death certifinate has been signed by the attending to age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23c. If	yes, outcome of pregnancy				23d. Date of deliv	an.
. Box	death e atter	iciar	in the past 12 months?	Live birth 2 Fetal deat Pregnant at time of death	h 3 □Ectopic pregnar 5 □ Other (specify)	ncy		Month	Day Year
P. 0.	at the 1 by th stache	Phys	9 □Unknown	Unknown					
	signed det	b	Part II. Other significant conditions contribut	ing to death but not resulting	in the underlying cause	given in Part I.		cco use contribute to	
S	w require been si should I	etec							
Division of Vital Records,	The lay	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
ita		BeC	25. Was case referred to medical			26. Place of Death		No 1 ☐ Yes	2 U No
<u>></u>	Q is X	유	examiner? 1 Yes 2 No Hospit	1 Unpatient 2 LEH/O	arpationt 30 BOA	· · · · · · · · · · · · · · · · · · ·	me 5 Residen	ce 6 Other (Speci	m Hospice
no	fune	tion:	1 Natural 5 Pending	a. Date of Injury (Month, Day Year) 28b.	Time of Injury M	ury at fork? □ Yes 2 □ No	28d. Describe how	injury occurred	·
<u>is</u>	Attending ir death. ector: After by the fune	fica	3 Suicide 6 Could not be	e. Place of Injury - At home, f			28f. Location (Stre	et and Number or Rui	al Route Number,
á	rs afte al Dir	Certification:	4 Homicide	building, etc. (Specify)			City or Town,	State)	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th compiletely filled in by the funeral	Medical	(Check only 2 Medical Examiner: (: To the best of my knowledge on the basis of examination a and manner stated.	e, death occurred at the nd/or investigation, in my	time, date and place, opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as s	stated. o the cause(s)
	To the within Fo the comple	Me	29b. Signature and tive of certifier		29c. Lice	nse number	290	I. Date signed (Month,	Day, Year)
	. , , ,		> Sto MD		D	24170		lanuary 29	1,2007
			30. Name and address of person who complete	ed cause of death (Item 23a)	1-1	1 0 11	1.7	21201	-/
			31. Date filed (Month, Day, Year)	OSPICE 838 /	V. Eutaw S	T Baltim	ore MD	21201	
	Sta Registra	_	JAN 3 0 2007	The second sold and the	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jan Day 24 2007 Collins 11:30 p M Philip Sr. Harry 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5116 Shelbourne Road Baltimore Arbutus If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 ★ M 2 □ F 216-42-9693 62 09/07/1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Baltimore Arbutus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5116 Shelbourne Road 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 20May 64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give 19May 66 Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Traffic Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Elmer Collins Ruth Stricker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5116 Shelbourne Road Arbutus, Maryland 21227 Elizabeth Alberta Collins- wife 20b. Place of Disposition (Name of cemptery, crematory or other place)
Loudon Park
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 01/29/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatu of Funeral Ser 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastri Sophagea month disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 1 🔲 Yes 2 N 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 5 Sesidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner requires that the death certificate be executed and burial-tra Box 68760, attending physician for use as the buria P.O. I Division or Vital Records,

or Attending Physician:

death.

Examiner Physician/Medical signed by the a þ Completed peen has je 2 page certificate director, Be ۵ After this funeral Certification:

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

items

"natural", or iten

the Medical

1 and 2 should be filed within Health and Mental Hygiene. 3m 27 is marked other than '

Health a

item 27

permit. Pages 1
Department of H
Important: If iter
any injury or oth

Physician

Director

Funeral

2

Completed

Be

2

MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director: A Medical 10+1

> State Registrar

ONCULOGIS T

29d. Date signed (Month, Day, Year) 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title

32./Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Dep	partment of Health are	nd Mental H	ygiene Reg. No. 2007	02362
1			Decedent's Name (First, Middle, Last)		2. Date of D	Death	3. Time of Death
	Physicia		Tsui-Hsiang Wen Chang		Month January	23, 2007	14:20 M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of		4c. County of Dea	
1	LXammi		Shady Grove Adventist Hospital	Rockville		Montgomer	у
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of B	Birth 9. Birth	thplace (State or Foreign ountry)
	Director		578-06-3917 1□M 2☑F 84 Yrs.	Monard Bayo Front	Oct.	Day, Year) 10, 1922 Chi	na´
	pu ,		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location			10d. Inside City Limits
	anyta show	_					1 □ Yes 2 No
	he M 28a-f otifie	S 1	Maryland Montgomery Rockville	10f. Zip Code		10g. Citizen of What Co	nuntry?
	Mith t		10e. Street and Number	20855		China	,
	eath	eral	17140 Amity Drive 11. Marital Status 12. Was Decedent Ever in U.S. 1:		in? (Specify Yes or N		erican Indian,
_	iner iner	Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, ———————————————————————————————————	Puèrfo Rican, etc.)	Black, Whit	te, etc.
2-003b	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	Asian
Ş	2 hor	Completed		cedent's Usual Occupation ve kind of work done during most	of working	16b. Kind of Business	/Industry
2	within 7 iene. than "r the Med		Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	or working		
N	filed wit Hygien other th ent, the	8		maker		Own Home	
yland	0 = 0 = 1	Be	17. Father's Name (First, Middle, Last)	UNKNO		lle, Maiden Surname)	
	should ind Men marke umatic	욘	Lian-Fu Wen	alling Address (Street and Number		ahar City as Tayon Ctata	Zin Cada)
Mar	12 st h and 7 Is n traun			Meadowvale Ter			
	1 and Health em 27 other tr				Jan. 28,	20c. Location - City or	
و	Pages nent of I int: If its iry or o		1 ☐ Burial 2 Micremation 3 ☐ Hemoval from State	Crematorium, Inc.	2007	Bethesda, M	Marvland
altimore,	artme	ı		22. Name and Address of Facility bert A. Pumphrey F			
n	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any Injury or other traumatic evence.		M00896	obert A. Pumphrey F 557 Wisconsin A	uneral Home ve. Beth	/Bethesda-Chevy esda. MD 208	7 Chase, Inc. 314-3501
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or head failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final	run Hisse mil	m na lima	disease	Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Chronic obst- Due to (or as a consequence of):	ructive pur	7		garis
	Examiner						
7	T #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
/	eute Ind transi	Examiner	that initiated events				
8760,	be executed sician and burial-transit	ığ	resulting in death) Last Due to (or as a consequence of):				
	ate the	dical	d				
9 X	leath certific attending p I for use as 1	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	alivery
Box	eath atten for u	ciar	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
o.	at the de by the a tached	ıysi	1 ☐ Yes 27 No 9 ☐ Unknown				
<u> </u>	res that signed b be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		d tobacco use contribute t	to the cause of death?
<u> </u>	w requires been sig should be				୬	Yes 2 No 3 F	robably 4 Unknown
ပ္ပ	aw re s bee	olete			24a. W	as an 24b. Were a	utopsy findings available completion of cause of
Vital Records,	Physician: The lar this certificate has al director, page 2	Completed				erformed3 death?	
<u>ta</u>	ian: irtifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place	of Death (Check onl		
<u>-</u>	hysic nis ce I direc	To	1 Yes No Hospital: 1 Inpatient 2 ER/Outpa		rsing Home 5 ☐ Re	esidence 6 Other (Spe	ecify)
u u	ng Pl		27. Manner of Leath 28a. Date of Injury 28b. Tim Natural 5 □ Pending (Month, Day Year) Inju	ry Work?		e how injury occurred	
Sio	tendi eath. tor: A the fu	cati	2 Accident investigation	M 1 Tyes 2 T		Chart and Alumban as 5	Turn I Poute Mumber
Division or	or At fiter d Direct in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office		n (Street and Number or F Town, State)	nurai Houte Number,
	pital ours a eral filled		29a. Certifier Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date an	d place, and due to t	he cause(s) and manner a	as stated.
	e Hos 24 h e Fun	Medical	(Check only 2 Medical Examiner: On the basis of examination and/cone) and manner stated.	r investigation, in my opinion, dea	th occurred at the tin	ne, date and place, and du	ue to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
			I Hlicia J. Mistry M!	D5973	೮	January	24,2007
	1		30. Name and address of person who completed cause of death (Item 23a) (Ty				
			Alicia T. Mistry, M.D., 9901 Medical	Center Drive,	Rockville	, Maryland 2	20850
	Sta Regist		31. Date filed (Month, Day, Year) \$2. Registrar's Signature	review			

			Please Type or Print in Black Ind			•	•			
			1- State of Maryland / Depar Registrar Cert	tment of Hea <i>ificate of De</i>		,	giene Reg. No.2 () ()	02363		
	Physici		Decedent's Name (First, Middle, Last) Audrey A. Crovo			2. Date of De Month Januar	Day Year			
A second	/Medic Examin		4	4b. City, Town, or Loca		<u> </u>	4c. County of Dea			
1 2		۵	Hospice of Baltimore - Gilchrist Ctr	Towson	า		Baltimo	ore		
	Funeral Director		213-20-1051 1 M 2XF 81 Yrs.		ours Min.	8. Date of Birt (Month, Da Sept.	y, Year) C	rthplace (State or Foreign Sountry) Maryland		
	within 72 hours after death with the Maryland lene. Than "Hatural" or items 23a or 28a-f show the Medical Examiner must be notified at	ı.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local				·····	10d. Inside City Limits 1 ☐ Yes 2 🕅 No		
	he Mi 8a-f	Director		eysville						
	a or 2		10e. Street and Number	10f. Zip Code			10g. Citizen of What C	ountry?		
	eath v	eral	10712 Pot Spring Road 11 Marital Status 12 Was Decedent Ever in U.S. 13 Wi	21030	nic Origin? (Spec	ify Ves or No	USA - 14. Race - Am	erican Indian		
	ter d	Funeral	1 Never Married 2 Married 1 Yes 2 No	as Decedent of Hispar Yes, specify Cuban, M	lexican, Puerto P	lican, etc.)	Black, Wh			
99	urs al al', or	þ	3 ¼Widowed 4 □ Divorced	∐Yes 2∭XNo <i>Sp</i>	pecify:		Specify: W	nite		
20	72 ho natur fical J	eted		nt's Usual Occupation		0	16b. Kind of Business	s/Industry		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hylgene. Important: If them 27 is marked other than "natural;", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Not use retired) lery worker			Paper Fac	ctory		
pu	al Hyle al Hyle othe vent,	Be C	17. Father's Name (First, Middle, Last)	18.	Mother's Name	(First, Middle,	Maiden Surname)			
Maryland	Ment Ment arked artic e	인	George Burdette	<i>P</i>	Anna A.	Youngin	eim			
Jar	2 short and is m						er, City or Town, State,			
e, P	1 and Health em 27 ther t		Joann Cuomo / daughter 10712 20a. Method of Disposition 20b. Place of Disposit	Pot Spring	g Ra.		sville, MD	21030		
Baltimore,	ages nt of l t: If the		1 X Burial 2 □ Cremation 3 □ Removal from State	ntory or other place)						
ij	artme ortani injun			ans Cemeter Name and Address of	PE 1114		Owings Mil	LIS, MD.		
Ba	Dep Imp any			12 NW Crai			neral Home rie, MD. 20	0715		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					Approximate Interval Between		
G.	Physician		Immediate Cause (Final disease or condition		active			Onset and Death		
	/Medical Examiner		Due to (or as a consequence of):							
34	_xammo	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
7	xecuted and il-transit	xamine	Cause (Disease or injury							
v O	exectin and rial-tra	Еха	that initiated events c							
68760	death certificate be ex e attending physician d for use as the buria									
89 ×	ertifica ing ph e as t	Physician/Medical	IF FEMALE:							
Вох	ath cath cath	ian/	23b. Was decedent pregnant in the past 12 ments?	ctopic pregnancy			23d. Date of de Month	elivery Day Year		
P.O.	0 0 0	ysic	1 ☐ Yes 2 2 Mo 4 ☐ Pregnant at time of death 5 ☐ 0 9 ☐ Unknown	Other (specify)						
	s that the ned by the detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in	Part I.	23e. Did to	obacco use contribute	to the cause of death?		
rds	tw requires that s been signed I s should be det	ed b	Demented, conjectiveheart Ja	Mure, o!	5struch	ofe 101	Yes 2. No 3□F	Probably 4 □Unknown		
eco	law re as be	Completed	Long disense, Stroke			24a. Was		autopsy findings available completion of cardse of		
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or Vital Records,	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner? Hospital:		Place of Death	(Check only o	one)	11		
0		-T	1 Yes 2 No ruspital 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of				dence 6 dother (Sp.	ecity) Hospice		
on	Attending Phr r death. ector: After thi by the funeral	tion	1	28c. Injury at Work? M 1 ☐ Yes		oo. Desember	now injury occurred	·		
Division	Attend or death ector: by the f	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28	3f. Location (S	Street and Number or F	Rural Route Number,		
	tal or rs after al Dire	Certification:	building, etc. (epochy)			Chy of You	wii, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death of (Check only one) (Check only	occurred at the time, destigation, in my opinio	date and place, a on, death occurre	nd due to the d at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)		
	To the within To the Comple	Me	29b. Signature and title of certifier	29c. License nun	mber		29d. Date signed (Mor	ith, Day, Year)		
			M Bothony Keles, uns	1250	205		JANUNY	29,2007		
•	.1.		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int)	C: -) 1	nd Zizi			
	4		W.A. Riley GBMC 6701 1	V. Charle	es Jt. E	alt.	md Zizi	عره		
	Sta Registr	_	31. Date filed (Month, Day, Yehr) 32. Poistrar's Signature	and						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 January 13:20PM Wayne Dodge Kenneth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec. 31, 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 XM 2 ☐ F 63 Washington, DC 226-56-4788 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 □ No Maryland | Prince George's Clinton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 U.S.A. 10651 Piscataway Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2/1/No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Steel Metal Mechanic Stee1/Meta1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be W. Thomas Dodge Edna L. Marcey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Dodge (Daughter) 10651 Piscataway Road Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Januar v 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria Virginia Mt. Comfort Cemetery 21. Signature of Funeral Service Lie 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Due to (or as a confi IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

Department of H Important: If Ite any injury or ot

Funeral

Director

28a-f show at

death with

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Inter 1f Item 27 Is marked other than "natural", or Item

Baltimore, Maryland 21215-0036

hthan "natural", or items 23a or 28a-f sh the Medical Examiner must be notified

Examine burial-trai physician Physician/Medical the as attending properties for use as detached the þ Completed by has page 2 certificate ector. Be within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. ٩

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records.

or Attending Physician:

the Hospital

Medical Certification:

24a. Was an autopsy performed' 1∐ Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

rtifier leann

29c. License number

29d. Date signed (Manth, Day, Year)

2□ No

1 ☐ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Obafemi Opesanmi, 7503 Surratts Road Clinton, Maryland 20735 MD

31. Date filed (Month, Day, Year)

29b. Signature and

32. Reistrar's Signature



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				epartment of Health and Mental Hygiene Certificate of Death Reg. No. 02365
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
	/Medic		Valentina Dzenitis	January 22, 2007 9:42 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
	Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Silver Spring Montgomery [Ay) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		577-48-7375 1□ M 2♥F 96 Yrs	Months Days Hours Min (Month Day, Year) Country)
	pu ,	E	Usual Residence of Decedent	
	anyla shov ed at	ž	10a. State 10b. County 10c. City, Town o	1 □Vos 2 ▼ No
	the M 28a-f lotifie	Directo	Maryland Montgomery Silve	r Spring 10f. Zip Code 10g. Citizen of What Country?
	with 3a or 1 be r	Ö	8710 Sundale Drive	20910 United States
	ms 2;	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-
9	after or ite mlne		1 Never Married 2 Married 1 Yes 2 No	1 Voc office Cooper
5-0036	ural",	d by	3 N Widowed 4 □ Divorced Year or Dates:	Specify. White
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g	at Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ToE	Janis Kazaks	Kristine Not available
Jar.	2 sho and isma raum	3		ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e,	1 and Health em 27 ther t	1		Somersworth Way, Silver Spring, Maryland 20902 sposition (Name of Date of 200, Location - City or Town State
aitimore,	ages nt of nt t: If Ite		Dulia 2 Micrellation 3 nemovalifoli State	crematory or other place) January 25,
	nit. Partme ortani injury			Journal of the state of the sta
ñ	permii Depar Impor any ir once.	ļ,		Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501
15.	R		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	
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ecords	equire een się ould b	ted		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown
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SION	nding tth. r; Afte e fune	tior	1XNatural 5 □ Pending (Month, Day Year) Injui 2 □ Accident investigation	y Work? M 1 □ Yes 2 □ No
<u> </u>	r Atte er deg recto by th	Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. "Of the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the complete of the funeral director.	Medical	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, do (2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, and due to the cause(s) and manner as stated. r investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	Fo the within Forther Somple	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			Jet of my	D 24348 01 22 2007
•	6	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type	
	Ψ		31. Date filed (Month, Day, Year) 32 pegistrar's Signature	rest Glen Road, Silver Spring, Maryland 20910
	Sta Registr			hashi

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4. 34 AM MICHAEL BILLY EARLY JAN YARY 27 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □ F New York Sep 25, 1958 Director 48 119-50-7170 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h. County r 28a-f show notified at 1 Yes 2 No Redline Director York Penn. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be U.S.A. 17356 406 Boyd Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ ★lo Specify: Specify: **Black** è 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mortgage Company Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Early Mike Early 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 406 Boyd Drive Redline, Penn. 17356 Alice Early Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 02/03/07 Arbutus Memorial Park 4 Donation 5 Other (Specify) 21. Sig of Funeral Service Li 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the diseas shock, or the lift failure. Approximate Interval Between Onset and Death ter he disease, or complications that caused the death. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cau (Final disease or condition resulting in death) Physician PULMONARY DAYS EDEMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, many, leading to in model, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examine physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical attending pt for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown RENAL DISEASE END STAGE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ISCHEMIC DILATED CARDIOMYOPATHY autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1. Inpatient ၉ 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 JANUARY, 27, 2007

V

State Registrar

31. Date filed (Month, Day, Year)

SOUTH HANGVER STREET, BALTIMORE, MD 21325 32. Registrar's Signature

JAN 3 0 2007

PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAHIRA

Box 68760 Records, Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

the Maryland

Baltimore, Maryland 21215-0036

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the or cedifier 1/29/07 D0057250 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Schos Madhirayu 201 Ballard Ave, Baltimore M.D. . Date filed (Month, Day, 32. Registrar's Signature State Registrar JAN 3 0 **ORIGINAL**

Medical

(Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	otate of that year		rtificate of	Death	, ,	ig. No.			
Dh	ysicia		1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	h Day Year	3. Time of Death		
	ysicia Medic		James Merton Engl					01 2		9:30p M		
Ex	amin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Death			
			Montgomery Genera 5. Social Security Number 6. Sec		last hirthday)	Derwoo		8. Date of Birth	Montgo	nplace (State or Foreign		
Fun Dire	eral ctor		496-10-3797	M 2□F 91	Yrs.	Months Days	Hours Min.	(Month, Day, 11-30-	Year) Co	MO		
land	-	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits		
Mary -1 •h	E E	to	MD Montgo	mery	San	dy Spring	g			1 ☐ Yes 2 ဩ No		
with the	to ad to	Funeral Director	10e. Street and Number 1637 Hickory Knol	1 Rd.		10f. Zip Code	20860	11	og. Citizen of What Co USA	untry?		
DESIGNMOVE, IMERY SETTION ALL 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-1 show	Examinar.mu	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 12⊠Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh:	e, etc.		
2 3-0 ithin 72 ho le.	Medical	Completed	15. Decedent's Edu (Specify only highest grad	e com <i>pleted)</i>	(Give		pation during most of work d)	ing	16b. Kind of Business/			
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yland ould be file Mental Hy arked oth	tic even	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Man Price) 19. William Charles Freeland 19. William Charles Freeland									
Mary Id 2 should have A	trauma		19a. Informant's Name/Relationship (Type, Print) Mark B. England/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 10815 Kingstead Rd. Damascus MD 20872									
TOTE, ages 1 ar ant of Hea	y or other		20a. Method of Disposition 1 ☐ Burial 2☐ Premation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crei	esition (Name of matory or other place).e Cremato	Ce)	Date 3	20c. Location - City or Beltsvil			
DAILIMOR permit. Pages Depertment of tmportant: If It	eny injur once.		21. Signature of Funeral Service-Licens		tion Servic							
Physic /Med			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LArge 13 out 05 tructor Due to (dr as a consequence of):									
Certificate be executed to and the control of the control of the certificate and the c	ŧ	al Examiner	Sequentially list conditions, if any, leading to an adiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	wanna of):							
K OO/OU, ertificate be ex ling physician	0 1	Medical	IF FEMALE:	1								
at at a	ched for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery Month Day			
Ords, F.O. requires that the	99	6	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	inderlying cause giv	ven in Part I.		acco use contribute to	the cause of death?		
e la hes	98 2	Completed	0 -	<i>)</i>				24a. Was ar autops perform	ned death?	topsy findings available ompletion of cause of		
	or, pa	ပို	25. Was case referred to medical				26 Place of Deat	1 Yes 2	IZNo 1 ☐ Yes	2 2 No		
OI VILA Physicien:	director,	ToB	examiner?	lospital: 1 Impatient 2	ER/Outpatier	nt 3 DOA Ott			nce 6 Other (Spec	note)		
E ig i	uneral	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur		28d. Describe ho		,		
DIVISION i or Attending after death. Director: Atte	in by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)			28f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,		
To the Hospital or Attend within 24 hours after death To the Funeral Director: /	etely filled	edicai Ce		sician: To the best of my kno ner: On the basis of examina and manner stated.								
To the within 7	comple	Mec	29b. Signature and title of certifier			29c. Licens			Od. Date signed (Month			
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	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		<i>U</i> /		· · · · · · · · · · · · · · · · · · ·			

State Registrar

JAN 3 0 2007 Janua & Spelle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02369 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 0135 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Modical Immore Baynew 5. Social Security Nu 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F Director 1929 Maryland 213-26-1738 Mar. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland | Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 USA 2901 Auden Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Motor Tours 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth (nmn) Fursch Charles Herman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Auden Court, Abingdon, Maryland 21009 Mary L. Einolf / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdn 2-1-07 Bel Air, Maryland 4 Donation 5 Dother (Specify) Fun Service bio 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final Physician intra Cerclora day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy perform 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Balkman MD 4940 Easter

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State

Registrar

31. Date filed (Month, Day, Year,

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32. Registrar's Sig

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1-	For State Registrar
	Registrar

State of Maryland / Department of Health and Mental Hygiene

		•	1 = For State Registrar	,	Cei	rtificate of l	Death		Rag. No.			
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	Funeral Director		067-26-5102	Sex 7. Age (In 1	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept.	y, Year)	9. Bi	rthplace (State or country) NY	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City	y Limits
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	r 28a	Director	10e. Street and Number	510	RCISCOL	10f. Zip Code			10g. Citi	zen of What C	ountry?	
	h with		509 Dean Avenu	e		211:	36		U.	U.S.A.		
	deal	Funerai	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No)-	14. Race - Am Black, Wh		
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alla	antal l) Be	William Cardew	,				an Davis		oum u mo)		
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ē,	f Heelth tem 27 other tr		20a. Method of Disposition	2	Ob. Place of Dispo		T	Date		cation - City o		
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00/00	certificate be executed nding physicien and use as the burial-transi	Medicai	" >	_ d								
×	death certific attending pl		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Te			2	23d. Date of de	elivery	
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'n	es the gned se de	by F	Part II. Other significant conditions	contributing to death but no	resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco u	se contribute t	o the cause of de	ath?
cords,	equire en si ould I		- THUAN	allexe	MI (AMO	<u>1</u>	1/2	Yes 2]No 3∏P	robably 4 U	nknown
ပ္သ	law ras be	ple						24a. Was		24b. Were a	utopsy findings a completion of ca	vailable
<u> </u>	The sete h page	Completed			L			perfo	med?	death?	s 2□No	
<u> </u>	clan: ertific actor,	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)	1		
5	shysi this c	မှ	1 Yes 2 No		2 ER/Outpatien			ome 5 Resi			ecity)	
5	Ilng F After Uner	e l	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Worl		28d. Describe	how injur	y occurred		
	daath daath tor; the	icat	2 Accident investigated 3 Suicide 6 Could not i	De Class of Injury	At home form at		Yes 2 □No	28f Location /	Stroot on	d Number or C	lural Route Numb	
	its efter ral Direction by	Certification:	4 Homicide determined	building, etc. (5)	ipecify)			City or To	wn, State,)		161,
25. Was case referred to medical examiner? 25. Was case referred to medical examiner. 27. Manner of Death 28. Death of the control of the							ne, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
,	To t With To t	ž	29b. Signature and title of certifier	20/1	MA	29c. License	e number	-	29d. Dat	e signed (Mon	th. Day, Year)	
	i,		30. Name and address of person who	completed cause of death	(Item 23a) Funa	Print)	0/70)	-//	24/-	200/	
	1/		/	1 5	2-100	750	RY		l	_		
b	⇒ Sta	te	31. Date filed (Month, Day, Year)	Registrar's S	Signature	ن ور						
	Registr	ar	JAN 3 0 20	107 10000	13 April	NEL !						
			VI 111 W	1.0	-							

DHMH 17 Rev 1/2001

			1 - For State of Management of State of State of Management of State of S	aryland / Depa		lealth and M	lental Hygie	ne 2007	02372
		- 7	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medic		Pamela Jean Forrester-Mon	ntour		J	ANUARY 8	27, 2007	7 3:30 A M
	Examir		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical		4b. City, Town, or	Towso	n	4c. County of Deat Balt	imore
figur.	Funeral Director		5. Social Security Number 218-48-3140 Usual Residence of Decedent	e (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 01/20/19	ar) 9. Birt Co Mar	hplace (State or Foreign unity) Yland
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I-f sh fied a	ţ	Maryland Baltimore	Timonium	n				1 ∐Yes 2 X No
	h the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
	th wit 23a c 1st be	a D	107 Northwood Drive		21093			U.S.A.	
	r dea	Funeral I	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spanic Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by F	1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced 1 Year or Dates:	No	1 ☐ Yes 2 🛛 No				hite
8	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	ed b	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ation	16h	. Kind of Business/	
15	nin 72 In "ins Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of work	ing	. Time of Business,	industry .
212	d within giene. er than " , the Mec	Completed	11	Manag	ger			estaurant	
pu	be filed v tal Hygie d other i	Be (17. Father's Name (First, Middle, Last)				(First, Middle, Maid		
yla	2 should be and Mental is marked o	ပ	Alden Russel Forrester				Louise W		
, Maryland 21215-0036	12 mg		19a. Informant's Name/Relationship (Type. Print) George Montour (Husband)				al Route Number, Ci imonium, l		
Baltimore,	jes 1 au of Hea if item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei				Location - City or	
Ë	permit. Pages Department of I Important: If ite any injury or o		4 ☐ Donation 5 ☐ Other (Specify)		rch Cemete			ltimore,	_
3alt	Departiment in portion		21. Signature of Funeral Scruce Licensee	22	2. Name and Addres Bri	is of Facility uzdzinski	Funeral:	Home, P.A	
	TO = 40 0		220 Ports Feet The disease or complications that course		<u>1407 Old 1</u>	<u>Eastern A</u>	venue, Es	sex, Mary	land 21221
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each limediat, cause (Final	ne.	er the mode or dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease r condition resulting death)	a consequence of):	LOPATHY				
	Examiner		CORDIA	AC ARREST					
		Je.	Sequentially list conditions, if any, feating to immediate cause. Enter I Indenting	a donsequents of).					
V	scuted nd rransii	Examiner		NARY FAIL	URE				
3760,	ate be executed hysician and the burial-transit	EX	Due to (or as	a consequence of):					
687		dical	d. FNEUMO	NTH .					
.O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of defi Month	very Day Year
<u>α</u>	that the	H.	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
rds,	quires n sign ald be	d by	ACUTE MYOCARDIAL INFARCTION	V			1 Yes	2 No 3 Pro	obably 4 Unknown
00	law red as bee 2 shou	lete	CHRONIC OBSTRUCTIVE PULMONA	ARY DISEASE	?	·	24a. Was an	24b, Were au	topsy findings available
or Vital Record	The law requires that the tee has been signed by the bage 2 should be detache	Completed			·		autopsy performed 1∐ Yes 2 X	prior to c	ompletion of cause of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death		No 1∐Yes	2 No
<u>-</u>	Physic this ce al direc	To E	1 ☐ Yes 2 No Hospital: 1 Inpatie		nt 3 DOA Othe	er: 4□ Nursing Hor	me 5 Residence	6 □Other (Spec	sify)
u	ding P After t funera	ü	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month, Da)	ry 28b. Time of Injury	Work		28d. Describe how in	jury occurred	
sio	Attending Physician: r death. ector: After this certific by the funeral director,	cati	2 Accident investigation			Yes 2 □ No			
Division	tal or A	Certification:	4 Homicide determined 288. Place of inju-	ury - At home, farm, stroc. (Specify)	eet, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	f examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Complete Compl	ž	29b. Signature and title of certifier	4	29c. License	number	29d. l	Date signed (Month	, Day, Year)
			De Juda 1	La m-v	D41	410	Jen	may 29	15, 2017.
_	16		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print)				
				D. 7601	OSLER D	RIVE TO	OWSON, MA	RYLAND	21204
	Sta Registr		31. Date filed (Month, Day, Year) 22. Registra	ar's Signature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per verb 8863 1-30-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician Elaine** Forni 11:23 P M Donna 28 2007 Januarv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel County Glen Burnie 932 Sunny Brook Drive ate of Birth Onth, Day, Year)
Jan.31 1949

9. Birthplace (State or Foreign Country)
West Virginia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1□ M 2√X Months 57 Director 217-50-8906 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Director Chestertown 1 Nes 2 No Examiner must be notified Kent Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21620 U.S.A. 23970 Langford Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 222 any liquy or other traumatic event. The New State Once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. Clerk/Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barc Μ. Don Workman Zada 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23970 Langford Road, Chestertown, Maryland 21620 Garrett L. Forni (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Grove Cemetery 02-02-07 Hillsboro, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, MarvIand 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impordiate Cause (Final disease or condition resulting in death) Physician Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transil To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) sister's 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this residence within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) North Broadway BAltiMORE MD 21231 Keith N PR 0 31. Date filed (Month, Day, Year) egistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2007

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 26^{Day} **Physician** Ann C. Folk /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville 5701 Granby Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-17-1931 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 KF Yrs 428-48-0499 75 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State items 23a or 28a-f sh ner must be notified Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 USA 5701 Granby Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ıral", or item I Examiner ı Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 Specify: Specify white 2 3 Widowed 4 Divorced Year or Dates Completed other traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 John E. Folk/husband Health em 27 i 5701 Granby Rd. Rockville, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State o ... Ь 1 ☐ Burial 2 🎉 remation 3 ☐ Removal from State Department of Important; If any injury or Chesapeake Crematory 1-27-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Crematic 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Cy Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

atory 1-27	-200	, per	rsville	FID	
ddress of Facility	. , S	ilver	Spring,	MD	
eral & Crem	atio	n Svc9	33 Gist	Ave 20910	
dying, such as cardiac	or respire	atory arrest,		Approximate Interval Between Onset and Death	
ancy /)			23d. Date of de Month	elivery Day Year	
e given in Part I.	236	e. Did tobacc		o the cause of death?	n
		a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 \(\sum \) No	е
26. Place of Dea	th (Check	(only one)			
Other: 4 \(\sum \) Nursing H	ome 5	Besidence	6 □Other (Sp	ecify)	
Injury at Work?			jury occurred	Sony	
Work? 1 □ Yes 2 □ No					
fice	28f. Loc City	ation (Street or Town, St	and Number or F ate)	Rural Route Number,	
ne time, date and place my opinion, death occu					
cense number	090	29d. [Date signed (Mon	th, Day, Year)	
200 Silver	Spr	ing, N	D 20902		

2007

7:10

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐Yes 2 No

Mississippi

ам

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State Registrar

Be

ို

Medical Certification:

31. Date filed (Month, Day, Year) JAN 3 0 2007

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only

one)



Hospital: 1 Inpatient

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

hours after death.

within 24 hours a

3□ DOA

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at t

28b. Time of

Ste 200 Silver Sp

07-00772 Kevin Fowlin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

evin rowiiii		1- For State	Department of Certificate of	f Health and Mental I f Death	Hygiene	200	7 02375	
Physic		Registrar 1. Decedent's Name (First, Middle,Last)		Dodan	2. Date of Deat		3. Time of Death	
ledical Exam	iner	MENIN AINTOININ POLO	lin		Month January 27	Day Year 7, 2007	2213 hrs	
		4a Facility Name (if not institution, give street and number) Sinai Hospital	4	4b. City, Town, or Location of Dea Baltimore	ath	4c. County of Deat	n	
Funeral			(In yrs. last birthday)	If Under 1 Year If Under 24H	Irs. 8. Date of Birt	h(MM/DD/YYYY) 9. Bir	thplace (State or	
Director		219-61-2118 1 M 20F	74 Yrs.		Feb 1	Teoroid		
	1	Usual Residence of Decedent	, _ ,		100 1	7,1130		
ow any		A 1 1	Oc. City, Town or Locati			10d. Inside City Limits		
Aaryland 28a-f show 1 at once.	ફ	Md Baltimore	Candsdo	10f. Zip Code		1 Yes 2 No		
he Ma 1 or 28 iffed a	Director	361 Bigley Ave		21227		g. Citizen of What Country?		
with 1 ms 23s		11. Marital Status 12. Was Decedent E		s Decedent of Hispanic Origin? (ican Indian, Black,	
death or iten	Funeral		No If Ye	es, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.		
rs after ural", miner	É	Widowed 4 Divorced of Pales: 15. Decedent's Education (Specify only highest grade compared to the pales).		Yes 2 No specify: t's Usual Occupation (Give kind o	F	Specify: B	ack	
72 hours at "natural	Completed	Elementary/Secondary (0-12) College (1-4 or 5-	during me	ost of working life. DO NOT use re	t work done etired)	16b. Kind of Business/	Industry	
5-0036 Iled within 72 Hygiene. I other than the Medical	ם	lyr	Eue.	Technician		Lens 1	matrois	
15-0 filed v I Hygi ed othe t, the I		17. Father's Name (First, Middle, Last)		18.Mother's Nar	ne (First, Middle, M	۸		
2121 ould be fill Mental H marked	To Be	Malston Fowlin 19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number o	S House Num	255a Ada	mso~		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene, item 7: in marked other than "natural", or items 23a or 28a-f she rerawmatic event, the Medical Examiner must be notified at once	-	Ralston Fowlin Fame	- 4/13/	V. Bogors Ave	A	A . 1	21215	
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		tion (Name of cemetery,	Date	20c. Location - City or	Town, State	
. = = = = = .		4 Donation 5 Other Specify:	Woodlaws	ما م	-3-07	Woodlaw	N, Ma	
Balti permit. Departr Import injury	را	21. Sign ture of Funeral Storice Licensee		ame and Address of Ficility	natman-		al Home	
Physician	6	23a, Part I. Enter the disease, or complications that caused the	ne death. Do not enter th	ne mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval	
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a, Gunshot wound of					Between Onset and Death	
Adminer		or condition resulting in death) Due to (or as a consec	uence of):					
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consection)	uence of):					
	Examiner	cause Enter Underlying Cause (Disease or mjury that initiated events resulting in death) Last Due to (or as a consec	uropen of					
und cuted .		events resulting in death) Last Due to (or as a consected d.	derice or).					
0 "	Medical	UNPENDED AMENDED						
3760, ficate be g physici s the buris		IF FEMALE: 23b Was decedent pregnant in the 1 Live birth		2		23d. Date of delivery		
Box 687 death certific the attending p ed for use as th	icial	past 12 months? 4 Pregnant at ti	mo of death	al death 3Ectopic pregr ner (Specify)	nancy	Month E	Day Year	
	Physician/	Part II. Other significant conditions contributing to death			-			
ords, P.O. I we requires that the as been signed by t	ρ	contributing to ceatri	out not resulting in the ur	nderlying cause given in Part I.		pacco use contribute to 2 ✓ No 3 Prob		
cords, law require has been si	Completed				24a. Was a		topsy findings available	
() = = ()	l di		<u></u>		autops	ned? death?	ompletion of cause of	
tal Rectian: The certificate ector, page	Be Co	25. Was case referred to medical		26 Place of Death (Check	1 Yes 2	No 1 Ye	s 2 No	
Vital hysician: this certif	일 일	examiner? 1 V Yes 2 No Hospital: 1 Inpatient			ing Home 5 R	Residence 6 Other		
_ .≡ . ≺ .∃ .	.: lo	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month. Day Yes Jan 27, 2007)	28b. Time of In 2033 hrs		28d. Describe ho Subject was	ow injury occurred		
Division tal or Attendi rs after death al Director: A	cati	2 Accident Investigation		1 Yes 2 No	29f Location (Ct	grad and Niver	The state of the s	
Division of Vital Hospital or Attending Physician: 24 hours after death: Funeral Director: After this certifi lely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify) Local		t, ractory, office building, etc.	or Town, Sta	reet and Number or Rui ate) ′s, Baltimore, MD	al Route Number, City	
Division of a Division of Attending Ph within 24 hours after death To the Funeral Director: After t completely filled in by the funeral		29a. Certifier (Check only 1 Certifying Physician: To the best of my l	knowledge, death occurr	ed at the time, date and place, an	d due to the cause	(s) and manner as state	ed.	
To the within To the Complet	Medical	one) 2 Medical Examiner: On the basis of exami and manner stated.	nation and/or investigation					
	2	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d Date signed (Mor		
		30. Name and address of person who completed cause of dea	oth (Itom 22a)	U.C.IVI.E.		January 28, 2007		
シ		Ling Li, MD Assistant Medical Examiner	. ,	t, Baltimore, MD 21201				
	tate	31. Date filed (Month, Day Year) 2007 39 Registrar's	- 60	29				
Regis	trar	JAN 3 V 2007 / January	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Cary Lewis Frey, Sr. A M 22, 2007 January 9:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Months Days Hours Min 213-42-4913 64 Dec. 26, 1942 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19201 St. Johnsbury Lane 20876 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔏 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Frey Alberta Tretheway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Frey/Son 2171 Raleigh Road, Hummlestown, Pennsylvania 17036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan. 27, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Bethesda, Maryland 4 Donation 5 Dother (Specify) 2007 Inc. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 0 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforn 1 Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

ဂ္

Funeral

Director

show

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Physician: The law requires that the death certificate be executed burial-transit and physician the attending for use à signed t funeral director, page 2 should been certificate has this After Hospital or Attending in 24 hours after death.
the Funeral Director: After the funeral parts of the funeral parts o

Division or Vital Records, P.O. Box 68760.

Physician/Medical 2 Be Completed Certification: To

Examiner

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

3 Suicide

4 Homicide

29b. Signature and title of certifier

1 ☐ Yes 25(No 2 ER/Outpatient 3 DOA Inpatient 27. Manner of Dr ath 28a. Date of Injury 5 Pending investigation (Month, Day Year) 1 Vatural **∠** Accident

6 Could not be determined

28b. Time of 28c. Injury at Work? 1 □ Yes 2 □ No

28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

esearch BLVD

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 M EWD

31. Date filed (Month, Day, Year) JAN30 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 28 2007 **Physician** FO) HERLOW 2127P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Examiner NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** XXM 2□F Months Days Hours Min. Director 72 8-26-1934 MARYLAND 212-32-7477 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f sl dical Examiner must be notified Director MD. N/A BALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 2 and 1 and 1 items 23a or 2 and 21207 USA 5622 STONINGTON AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-LABORER BALTIMORE AIR COIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE FOY MATTIE CHESSON P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA FOX (WIFK) 5622 STONINGTON AVE. BALTIMORE, MARYLAND 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State $2-5^{\frac{Date}{2}}007$ 1 Burial 2 Cremation Removal from State 4 ☐ Donation /5 ☐ Other (Specify) GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND Service Lyensee ONATHAN HIBN R. Name and Address of FacilityREDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part^{*}. E fter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, ir heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate vause (Final disease or ondition resulting in death) arta **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ohysician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. GRACED HORO MA Morro 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1□ Yes 2 1 No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1. Natural I hours after death.

-uneral Director: /
ely filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 054288 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Youthwest Hospital Center 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2007

			For State Registrar	State	of Marylan		artment of F				giene Reg. No.	007	023	78
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	Physicia /Medic	71	JULIA	BRIDGET	GOVANS					JANUARY		2007	6:20	P ^M
	Examin		4a. Facility Name (If not institution	n, give street and no	ımber)		4b. City, Town, o	r Location	of Death		4c. C	county of Death	1	
			Cherry Lane N				Laurel					ince Ge		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day	r, Year)	Cou	place (State o	
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	and t		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation			-			10d. Inside Ci	ty Limits
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	28a	rec	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	intry?	
	3a ol	Funeral Director	702 5th Street				20707				U.S	U.S.A.		
	ms 2	ner	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic O	rigin? (Spe	ecify Yes or No-	. 14	4. Race - Amer Black, White		
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215-0036	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:							Specify: American		
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Ë	hould d Me mark matic	은	19a. Informant's Name/Relations	hin (Tyne Print)	 -	19h Maili	ng Address (Street	l					in Code)	
<u>8</u>	d2s than 7isi		James N. Washir		son		Snowden				-	Marylan		18
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saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State		matory or other pla onal Mem		1/2	9/07	T.aur	cel, Ma	rvland	
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat							ir y rana	Approximat Interval Bet	te
	Physician	07.3	Immediate Cause (Final		each line. lzhiemer							9	Onset and l	Death
	/Medical		disease or condition resulting in death)	a	o (or as a conseq		rease						JVCI J	years
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<u> </u>	l or A after Dire	Certification:	4 ☐ Homicide determ	nined buil	ding, etc. (Special	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow	vn, State)	77077207 07 710	10010 11011	
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	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or i	nvestigation, in my	opinion, de	eath occur	red at the time,	date and	place, and due	to the cause(s)
	To th Vithir To th	Me	29b. Signature and title of certifie	- 1			29c. Licens	se number			29d. Date	signed (Month	, Day, Year)	
)			D 24721 January 24, 2007											
			30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type				-			'	
	Oj		Syed Sadiq, M.I	14333	Laurel	Bowie	Road, Su	ite 2	208	Laurel,	Mary	land 2	20708	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20a per fin 863 1-30-07 vt. State of Maryland 9 Bepartment of Health and Mental Hygiene 0 0 7 02379 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death GEONGE **Physician** GRIFFIN 6:00 P M 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MD 21283 MON JECOURS HOJPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 1 M 2 ☐ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 63 214-40-766 Yrs. MD Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 8 2 No Baltmore Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 710 N. Was Decedent Ever in U.S. Armed Forces? 1 Deves 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Aprilens 1 ☐ Yes 2 € No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Constave from Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Mamie UNK Goines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth a important: if item 27 is eny injury or other train 2006. Son Maurice GniPPM 4508 mountain view, Baltmore MO ZIZZQ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date iel 2 Cremation 3 Removal from State 21. Signature of Fund ral Service Lines

22. Name and Address of Facility

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Approximate | Appro Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of): Examiner PNEW MONIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CANCER METASTATIC Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEVENE HYPONATREMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 1 No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 239 Carthur (Check only one) 29c. License number 0 / 49 49 29b. Signature and title of certifier workly with the signature and title of certifier workly with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and title of certifier with the signature and the signa 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

JAN30 2007

JANET V. MOGAREY IND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1/23/3007

now w. SALTIMONE ST., BAGIMUNE, MO HOB3

To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director, After this certifice completely filled in by the funeral director, p

the Marylend

Pages 1 and 2 should be filed within 72 hours after death

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-translt

signed by the a

and Mental

Baltimore, Maryland 21215-0036

is marked other then "natural", or items 23a or 28e-f ehow sumatic event, the Modical Examinar must be notified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Year January 25, 200 Physician Lewis Goodwin Willie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more STEME Security Number 7. Age (In yrs Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 0 14 Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Months Hours Min. 227-48-3328 66 1Ö 40 Director NC Usual Residence of Decedent r 28a-f show notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Director Baltimore Yes 2 No MD NΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Important: If the T2 Is marked other than "natural", or Items 23a or any finury or other traumatte event, the Medical Examiner must be rany infury or other traumatte event, the Medical Examiner must be r 21217 U.S.A. 1919 Division Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 10th grade (0-12) College (1-4or 5+) Factory Worker Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Martin William Goodwin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Goodwin-Wife 1623 North Gilmor St, Baltimore, Md 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/1/07 Piney Grove Roanoke Rapids, NC 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Licensee Genald 21215 Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition teaching in death) **Physician** /Medical Duy to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9☐Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate perform 1∐ Yes 2 No 2□No Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After To the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 3

0

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Javadi 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of Ma	-	•	artment of He tificate of D			ene g. No. 2 0 0	7 02	381
	Physici		Decedent's Name (First, Middle, La	catherin	E MILD	RE	D GRUEL		2. Date of Death Month JAN . 27	Day Yea	3. Time o	
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City, Town, or L	ocation of Death	21114	4c. County of De	ath	
	Funeral Director		213-20-6350	Gex 7. Age I□M 2∏GF	(In yrs. last birth	rs.		If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,) 4 / 1 4 / 1	(, Year) Country)		
	Maryland f ehow	٥٠	Usual Residence of Decedent 10a. State 10b. County MD CARROL	,L	10c. City, Town						10d. Inside C	ity Limits
	3s or 28e-	I Director	10e. Street and Number 341 FAIR AVE.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip Code 21157		100	g. Citizen of What o	Country?	
36	s after death , or items 2	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ∑ N If Yes, Give		1	Vas Decedent of Hist f Yes, specify Cuban, □ Yes 2∑ No	panic Origin? (Spec , Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ar Black, Wi Specify: W		
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Maryla		٦ و	CHARLES H. FRANK FLOREN 19a. Informant's Name/Relationship (Type, Print) JEFFREY GRUEL – SON 341 FAIR AVE., WESTMIN						Route Number, (, Zip Code))
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	/Medic Examir		4a. Facility Name (If not institution, give si	treet and number)	enter		or Location of Death	January	4c. County of Deatl	
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	urs after dea al', or items Examinar ma	by Funeral	11. Marital Status 1 1 Never Married 21 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2X N	f Hispanic Origin? (Suban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:Whi	etc.
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, mar	₽ £ ₹ ₹ ₽		W. Michael Garrity	Husband	408	Pixie I		llersvill	City or Town, State, 2 Marylane	21108
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Baiti	permit. Department imports any inju		21. Signature of Funeral Service License	enss	22 E	Name and Add Surgee—He 631 Fal	lress of Facility enss—Seitz Is Road, I	Funeral Baltimore	Home, Inc Maryland	. 21211
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cords, r	requires thet the een signed by th nould be detache	ed by Physl	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause (given in Part I.	23e. Did tob	acco use contribute to 2 No 3 □ Pro	
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Division	ending P lath. or: After t he funera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	uryat łork? ∐Yes 2∐No	28d. Describe ho	w injury occurred	
ž D	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	(y)			City or Town,	,	
	the Hosp in 24 ho the Fune ipletely fi	ledical	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	wiedge, deal ition and/or in	vestigation, in my	opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
)	or tile con	×	29b. Signature and little of certifier	ua w	mO		nse number	5	d. Date signed (Month	Day, Year)
	01		30. Name and address of person who con	mpleted cause of death (Item	n 23a) (Туре. Ме.А	Print) CC	varies (viles	ital Prive	Glen
	Sta Regista	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa		4)	······································		· · · · · · · · · · · · · · · · · · ·	

Garrity, Beuich

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev Physician Kallower Jelen 2017 25 20 ,7 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Thankord Rol (15 c/0 Balyman Hann, 1 ha If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Months 219-22-5583 82 Director 08/13/1924 MD Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28e-f show any Injury or other treumstic event, the Medical Examinations must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 X Yes 2 □ No Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21224 USA 6040 Harford Road Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: African American Be Completed by 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cashier Reeds Drug Store 6th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Mae Smith Granison Carter 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 518 Hardwood Avenue; Baltimore, Maryland 21212 Alice Galloway / Daughter 20a. Method of Disposition
14 Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 01/31/2007 Baltimore, Maryland Arbutus Memorial Park 21. Signature of Funeral, Service Licensee 22. Nama and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street: Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Anongia 4 Eeli Examiner Due to (or es a consequence of): by Physician/Medical Examiner The law requires that the death cartificate be executed attanding physician and for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): signed by the a Id be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? certificata has been s irector, page 2 should Completed antrails 1 ☐ Yes 1 ☐ Yes 2 ☐ No Director: Aftar this certific d in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ٩ 1 Yes 2 No 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide within 24 hours a To the Funerel Completely filled edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 07 Klake 3/295 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Sute 6701 N Charles 4202 KLOZSE 31. Dete filed (Month, Day, Year) 32. Pagistrer's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 3 0 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 10:10 AM^M Harry Gassaway January 16, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Millenium Marley Neck Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk **Funeral** Days Hours 1 M 2 □ F Mar 17, 78 1928 Director 215-24-9498 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits un "natura!", or Items 23a or 28a-f show Medical Examiner must be notified at Anne Arundel 1 ☐ Yes 2√∑ No Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7575 E. Howard Road 21061 USA Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U. unk Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the unk s 1 and 2 should be filed v f Health and Mental Hygie item 27 is marked other 1 other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. 7575 E. Howard Road Glen Burnie, MD Millenium Marley Neck 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Sign ture of Emeral Project Idenseed Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him deal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not/9sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ Mo 1 Inpatient 2 ER/Outpatient 3 DOA P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of De th 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

that the death certificate be executed Records, P.O. Box 68760, physician Division or Vital this Hospital or Attending death. after

filed within 72 hours after death with the Maryland

I Hygiene.

other

Maryland 21215-0036

Baltimore,

burial-trar attending p ģ signed ≿ certificate has page 2 funeral After Director: npletely filled in by the within 24 hours af

To the Funeral D

completely filled i the ျှ

> State Registrar

Medical

29a. Certifier

29b. Signature a

31. Date filed (Month, Day,

title of certifier

DHMH 17 Rev 1/2001

2. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

#231 Annapolis MD 21401

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Many		artment of Health and rtificate of Death	, ,	giene	02385
Division		Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
Physic /Med		Mary Romaine Harden			January	06 0000	2:00 A. M
Exami	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De		4c. County of Deat	
		10932 Powers Ave. 5. Social Security Number 6. Sex 7. Age (I	a como do od biodo do d	Cockeysville		Baltimor	
Funeral Director		45M 65M	n yrs. last birthday) 72 Yrs.		lin. 8. Date of Birth (Month, Day Feb. 13,	7, Year) 9. Bin	hplace (State or Foreign buntry) keysville,MD
		Usuel Residence of Decedent	,,,		160.15	1734 000	keysville,MD
arylan ehow	_		Oc. City, Town or Lo				10d. fnside City Limits
8a-f	Director	Maryland Baltimore County	Cockeysv				1 □Yes 2 No
be filed within 72 hours after death with the Maryland half Hygiene. Ide thygiene. do ther than "nature!", or terme 23a or 28a-1 show event, the Marilcal Exertirat must be notified at	D	10e. Street and Number 10932 Powers Ave.		10f. Zip Code 21030		10g. Citizen of What Co United Sta	•
leath me 23	Funeral	11. Marital Status 12. Was Decedent Eve	er in U.S. 13. \		(Specify Yes or No-		
after of the state	F	1 Never Married 2 Married 1 Yes 2 No		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	ierto Rican, etc.)		e, etc.
ours a	dby	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	Section 2	1 ☐ Yes 2 € No Specify:		Specify: W	hite
72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of	working	16b. Kind of Business	Industry
withir ene. then	m C	Elementary/Secondary (0-12) College (1-4or 5+) 08 n/a	ille. L	DO NOT use retired) Cashier		Restau	rant
Hygi ent.	Be Co	17. Father's Name (First, Middle, Last)			Name (First, Middle,		
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental August 1997.	70 B	Reuben Lester Spicer		Agnes	Kearney		
and 2 should eath and Men m 27 is marke	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or	Rural Route Numbe	r, City or Town, State, 2	Zip Code)
and and and and and and and and and and		Mrs. Brenda L. LaMotte (Daught				lle, Maryl	
permit. Pages 1 and 2 should bepartment of thealth and Man Important: if them 27 is marke any injury or other traumatic.		1 Neurial 2 Cromation 3 Demouslifrom State		natory or other place)	Jan.30,	20c. Location - City or	
t. Pa rtmen rtant:		11. 11.		alley Mem.Gard.		Timonium, I	
Departit. Departitions		21. Signatur of Funeral Service Licensee	e, A. 2.	eaceful Alternat 325 York Road	ives Fune Timonium,	ral&Cremat Maryland	ion Ctr.,P.A. 21093
Physician		23a. Party Exter he dis A., or complications the caused the shock of high fit failure. List only one cause in each fine. Immediate Cause (Final disease or condition		er the mode of dying, such as card			Approximate Interval Between Onset and Death
rate be executed whysicien and the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a condition of the cond	onsequence of): Itiple onsequence of):	Sclerosis			10 years
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending physicien and compistely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 ☑ No 9 □ Unknown 23c. ff yes, outcome of the first past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetel death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
s that	by P	Part ff. Other significant conditions contributing to death but n			23e. Did to	bacco use contribute to	the cause of death?
equire en sig	led	Congestive Heart	Failur	·c	1 D Y	es 2⊠No 3⊟Pr	obably 4 Unknown
ne lawr has be ge 2 sh	Completed				24a. Was a		stopsy findings available completion of cause of
The cete h	Con				pertor	med? death? 2 No 1 ☐ Yes	
ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?			Death (Check only or		
Phys rat dir	2	1 Inpatient	2 ER/Outpatien	at 3 DOA Ciner 4 Nursin		ence 6 Other (Spe	cify)
ding th. Afte	tlon	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	ear) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	20d. Describe ii	ow injury occurred	
r Attending Physical discussions of the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Pface of Injury	At home, farm, str		28f. Location (S	treet and Number or Ru	ural Route Number,
s effe	Cert	4 Homicide determined building, etc. (Specify)		City or Tow	n, State)	
To the Hospitel within 24 hours of To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examt manner stated	amination and/or inv	n occurred at the time, date and playerstigation, in my opinion, death or	ace, and due to the occurred at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)
To th withir To th	×	29b. Signature and time of certifier		29c. License number	1	29d. Date signed (Mont	
		I les a MI)		D5744	14	Jan 26	, 2007
5		30. Name and address of person who completed cause of death Alexander Chen,	MD	D 5744 Print) 603 Woodb	ine Terr,	Towson.	MO 21204
St Regis	tate trar	31. Date fifed (Month, Day, Year) 2007 32. Registrar's	Signature	els)			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Mari followa nuary 200 4a Fecility Neme (Cot institution, give street and number) of Death Baltimore 8. Date of Birth (Month, Day If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) Days 1 □ M 2 □XF 79 220-18-4629 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkville 1 ☐ Yes Ž☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8710 Emge Road 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) At Home

Homemaker

20b. Place of Disposition (Name of

Parkwood Cenetery

22. Name and Address of Fecility EVANS FUNERAL

AND CREMATION

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 9

228 High Meadow Terrace, Abingdon, Maryland

Date

2-1-07

CHAPEL

SERVICES

20c. Location - City or Town, State

Parkville, Maryland

8800 Harford Road Parkville,MD₂₁₂₃₄

Mary Adams

Physician /Medical Examiner

injury or other

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Nems 23s or 28s-f show

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or flams 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at

Be Completed by Funeral Director

Physician

/Medical

Examiner

10a. State

MD

12 17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Henry Joseph Whitthauer

Theodore Holloway, Jr-son

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature-of Funeral Service Licensee

31. Date filed Month, Day, Year)

JAN 3 0 2007

Funeral

Director

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

ours efter death. within 24 hours e To the Funeral C completely filled

	23a. Part1. Enter the diseese, or comp shock, or heart failure. List only of	lications that caused the deat one cause on each line.	th. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death						
	Immediate Cause (Final disease or condition resulting in death)	· Cardi	u Arr	hythmia		onsocially beauty						
		Due to (d	or as a consequence of	f):/		1						
		b				i						
Exan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequence o	():								
	that initiated events resulting in death) Last	Due to (o										
		d										
	Part It. Other significant conditions co	ntributing to death but not res	sulting in the underlying	cause given in Part I.	23b. Did tobacco use conf	tribute to the cause of death?						
y rmy	Diabetes				1 □ Yes 2 □ No	3 Probably 4 Unknown						
פופח	End Stage	of Kidn	rey Dise	uso	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause						
2	Deubitus		•		1 □ Yes 2 □ No	of death? 1 ☐ Yes 2 ☐ No						
200	25. Was case referred to medical examiner?											
2	TEL TES ZELIZAG	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□		lome 5 ☐ Residence 6 ☐ Othe	r (Specify)						
ations	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre	ed						
Ser mic	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Finding City or Town, State)											
IROIDS	29a. Certifier 1 Certifying Phy (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due										
Σ	29b. Signature and title of certifier 29d. Date signed (Month											
	Doos9855 January											
	30. Name and address of person who c	MOZ1234										

State Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Part Part		_1	For State Of IVIA State Registrar Decedent's Name (First, Middle, Last)		tificate of D	2.	Reg. No.	2007	3 Time of Death
Social Security Number 2 - 6. Best Security Number 2 - 6.	/Medic	al L		Contan	4b. City, Town, or	Location of Death		,	<u> </u>
The State 10c. Clay 10c. C	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs. 8.	Date of Birth		
Chimes C	D		10a. State 10b. County	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					10d. Inside City Limits 1 1 Yes 2 □ No
Chimes C	vith the Mar or 28a-f sl be notified	Director	10e. Street and Number	Baltimo	10f. Zip Code	5	10g. Citi		untry?
Emergency contains that conditions are a consequence of control for a same control for a same control for a same consequence of control for	urs after death v al", or items 23e Examiner must	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	ever in U.S. 13. V	Was Decedent of His If Yes, specify Cuba	spanic Origin? (Specify n, Mexican, Puerto Ric		14. Race - Amer Black, White Specify: Afr	etc. rican- rican
A Donation S Other (Specify)	ed within 72 ho ygiene. her than "natur it, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 11 th College (1-4or 5-	(Give	kind of work done of DO NOT use retired	uring most of working)	C	Chimes	naustry
A Donation S Dotter (Specify)	nould be fill Mental H narked oth	Be	Eddie S. Hawkes	19b. Maili	ng Address (Street	Dais	v Fitzge	rald_	(ip Code)
Physician (Modical Examininer Part II. There the disease, or complications that adjusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Franchise) and the production of t	ages 1 and 2 shent of Health and tr. If item 27 is ny or other traun		Thelma D. Hawkes/Sis In 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State,	Law 3614 20b. Place of Dispo cemetery, cre	4 Wabash osition (Name of matory or other place	Avenue,	Baltimo	ore, Md	21215 Town, State
Due to (or as a consequence of): ACUTE RENAL FAILURE Due to (or	permit. F Departme Importar any injur		21. Some e of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each fix	the death. Do not en	200 Libe	rtv Rd.	Randall		Md 21133 Approximate Interval Between
Due to (or as a consequence of): The property of the past 12 months? 23d. Date of delivery 23d.	/Medical Examiner	er	disease or condition resulting in death) Due to (or as ACUTE	a consequence of): RENAL FA	ILURE				
FFEMALE: 23d. Date of delivery 23d. Date of deli	te be executed ysician and le burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as	a consequence of):					
25. Was case referred to medical examiner?	ne death certifica the attending ph	ysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 I lakpown	2 ∐Fetal death 3		/			
25. Was case referred to medical examiner?	signed by		Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause giv	en in Part I.			
28. Place of Death (Check only one) 28. Place of Injury at Work? 1 Yes 2 No 28. Place of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 28. Date of Injury at Work? 28. Date of Injury at Work? 1 Yes 2 No 28. Date of Injury at Work? 28. Date of Injury at	The law requate has been page 2 shoul	Completed					autopsy performed? 1□ Yes 2	prior to death?	completion of cause of
29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29c. License number (Check only one) 29c. License number (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature (Check only one) 29d. Date signature	nding Physician: th. After this certific	To Be	examiner? 1	urv 28b. Time	of 28c. Inju	ner: 4 Nursing Homo ry at 28 rk?	e 5 Residence		acify)
(oballo, ml) D25886 January 24, 20	oltal or Atternar after dea rai Director	Certifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of in building, e	t of my knowledge, de:	ath occurred at the t	ime, date and place, at	City or Town, Sta	(s) and manner a	s stated.
(oballo, ml) D25886 January 24, 20	o the Hosp ithin 24 hou the Fune	Medical	(Check only one) Amedical Examiner: On the basis of and manner s	of examination and/or	investigation, in my	opinion, death occurre	d at the time, date a	ind place, and du	e to the cause(s)
30. Name and address or person who completed cause of beauti (item 250) (1) politically			30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print)			1	24, 2007
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		tate	L. CEBALLOS, M.D. 761	01 OSLER		TOWSON, MA	ARYLAND	21204	

			Pleas	e Type or Pri								_	ole.	
			For State Registrar	State of M	aryland	•		of Health of Death		ental Hy	/gien Reg. N	20	07	02388
п	1 20	-1	Decedent's Name (First, Middle,	Last)	-				.	2. Date of D	eath	ay	Year	3. Time of Death
	Physicia /Medic		Christopher K	evin Hawk	ins :	III				0	12	-	07	2045 M
2	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Tov	vn, or Location			4	c. County	of Death	
	Funeral Director		5. Social Security Number N/A	HOSD, 1.3.1 Sex 7. Ag 1X M 2□ F	je (In yrs. la	as <i>t birthd</i> ay). Yrs.	If Under 1 Y Months D	Year If Under	24 Hrs. Min.	8. Date of B (Month, D	ay, Yea		Coun	**
	D		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation	1 Z		1-12-	-0 /			yland Od. Inside City Limits
	e Maryk 3a-f sho tified af	ctor	Maryland Anne	Arunde1	00	dento	n							1 □ Yes 2 No
	vith th	Directo	10e. Street and Number				10f. Zip Co	de			10g. 0	Citizen of W	hat Coun	try?
	eath v	eral	655 Chaple Ga	te Dr.	Ever in H 9	13 1		1113	rigin? (Sne	oifu Vec or N	lo.	USA 14 Bace	- Americ	an Indian
S S	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show di-al Examiner must be notified at	by Funeral	11. Marital Status 1	Armed Forces?	?		f Yes, specify			Rican, etc.)	cify Yes or No- Rican, etc.) 14. Race - Am Black, Wh Specify: E			etc.
-0020	2 hour		15. Decedent's	Education		16a. Deced	lent's Usual C	ccupation			16b.	Kind of Bu	siness/Inc	lustry
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and	2 should be filed and Mental Hygis is marked other aumatic event, ti	BeC	17. Father's Name (First, Middle, L				.,,	18. Moth	er's Name	(First, Middl			e)	
<u>Xaa</u>	should b ind Menta i marked umatic e	P.	Christopher K			1				Keg1				
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationshi					reet and Numb						,
ย์	es 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Tiaunna Kegle 20a. Method of Disposition	r(Motner)	20b. Pla	ace of Dispo	sition (Name	e Gate		<u> </u>		Location -		
Ē	Pages nent of nt: If It		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Sp.		1		natory or othe remat		1-29	-07	Ba	1tim	ore	, Md.
galti	permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service L	censee		M	Mame Red	ddees of Cacil	Sons	Mort	uar	у, Р	.A.	
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		. 00	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	omplications that cause nly one cause on each l	d the death. ine.	N		1		or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	V F L		EM4	Juk:	ty				_	30 min
	Examiner		Sequentially list conditions	b	·									
25	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury	Due to (or as	a consequ	ence of):							II.	
7	executed n and ial-transit	xaminer	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):							-	
8/PU	eath certificate be exattending physician for use as the buria	dical												
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C. Box	that the death ed by the atten detached for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregr Other (speci					Mor		Day Year
Ţ	requires that een signed by nould be deta	by Ph	Part II. Other significant condition	s contributing to death t	out not resul	Iting in the ur	nderlying caus	e given in Part	l.	23e. Did	tobacc	use contr	ibute to th	e cause of death?
cords	w require been sig should b									1] Yes	2 □ No	3 ☐ Prob	ably 4 Unknown
ě	e law has b je 2 st	Completed								24a. Wa aut per 1□ Yes	opsy formed?	, d	Vere autoprior to cor leath? □Yes	psy findings available inpletion of cause of 2 No
VITAI	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hagnital: a #					e of Death	(Check only	one)			
9	Phys r this ral dir	٠ <u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatien 28b. Time of				me 5 Res 28d. Describe)
0	Attending Ph r death. ector: After th by the funeral	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Da	ay Year)	Injury	м	Injury at Work? 1 ☐ Yes 2 ☐		Log. Describe	S TIOW III	jury occurr	ou .	
DIVISION	= 5 te o	Certification:	3 Suicide 6 Could no 4 Homicide determin	Zoe. Flace of In	jury - At hor tc. (Specify	me, farm, str	eet, factory, o	ffice		28f. Location City or To	(Street own, Sta	and Number	er or Rura	I Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical C		Physician: To the best xaminer: On the basis of and manner s	of examinat									
	To the within To the Comple	Me	29b. Signature and title of certifier	Man-	om c)	29c. L	cense number			29d. [ate signed	(Month,	Day, Year)
)			michae	1 P Pars	ns 1	ND	4	14/415	2		-	130	· .	
	ϕ		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type,	Print)_	to. Nat	_	Ke, Si	uit.	2232	Co	Honsville,
e e	Sta Registr		31. Date filed (Month, Day, Year) JAN 3 0 2	32. Regist	rar's Signat	ure Jose	1		, , ,					
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		Please Typ							-		•	
		1 _ State	ate of Ma	arylan					Mental Hy		000	7 00000
	-	Registrar 1. Decedent's Name (First, Middle, Last)			Ce	rtificate o	ים זו	eatri	2. Date of D	Reg. No	200	3. Time of Death
Physic		James H.	H	ess		SR			Month	Da	28 200	
/Medi Exami		4a. Facility Name (If not institution, give street					n, or Lo	ocation of Dea		40	County of De	
		University of Manyland	Medica	ul Ce	nter	Balti					NIA	
Funeral		5. Social Security Number 6. Sex			ast birthday) Yrs.	If Under 1 Ye Months Day		If Under 24 Hrs Hours Min	(Month, D	av. Year.)_ (rthplace (State or Foreign Country)
Director		Usual Residence of Decedent		69) 113.				June 1	,193	/ Ma	ryland
yland yland at		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
e Mar 3a-f sl tifled	cto	Maryland Baltimore			Middl	e River						1 ☐ Yes 2 ☐XNo
vith th	Funeral Director	10e. Street and Number				10f. Zip Cod		0			tizen of What C	Country?
eath v	eral	833 Thimbleberry Roa	Vas Decedent	Ever in 11	S 13		122		Specify Vos or N		USA 14. Race - Am	erican Indian
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permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remo	val from State	0	emetery, cre	osition (Name of matory or other	place)		ruary		ocation - City o	
it. Pa		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee/		Oar		Cemete			2007		dalk,Ma	
Department any is		21. Signature of the large service Electrises	MN	XU	2/ 7	onnelly 110 Sol	"Fů ler	neral I	Home of Road,	Dund Dund	lalk,P.A lalk.MD.	· 21222
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ires that the de signed by the a		Part II. Other significant conditions contributions	uting to death b	ut not resu	ulting in the u	inderlying cause	given	in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
quires n sign lld be	d by	Klebsiella Bacteren	110-						1 🗆	Yes 2	2 ⊠ No 3⊟1	Probably 4 ☐Unknown
aw require s been sig	olete								24a. Wa	ร ลก	24b. Were	autopsy findings available
Physician: The laver this certificate has stall director, page 2.	Completed								per	opsy formed? 2) € N	death?	
slan: ertifice ctor, p	Be C	25. Was case referred to medical examiner?					2	26. Place of De	ath (Check only			:5 2 <u>/2</u> 110
hysic this co	힏	1 Yes 2 No Hosp	1 🔼 Inpatie			III 3 DOA	Other:	4 Li Nursing	Home 5 ☐ Res	idence	6 □Other (Sp	ecify)
dlng F h. After funera	io ::	1 Natural 5 □ Pending	8a. Date of Inju (Month, Da	y Year)	28b. Time o Injury				28d. Describe	how inju	ary occurred	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physicia 2 Medical Examiner:	n: To the best	of my kno	wledge, deat	th occurred at th	e time	, date and place	ce, and due to th	e cause(s) and manner	as stated.
the H hin 24 the F	Medical	one)	and manner st	ated.								
S o o	2	29b. Signature and title of certifier	2	100		29c. Lio					ate signed (Moi	
Ø		20 Namo and a titure of		PIL) 000 T	P19	169	1		Jano	iany 21	8 2007
A		30. Name and address of pers who complete South Green			123a) (Type,	e MD	21	201 (TOUTALL	Th/	Dickin	3 2007 1504
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Regist	irar	JAN 3 0 2007	Many	A.	o hove	2 S						

DHMH 17 Rev 1/2001

State

completely

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 3 0

29c. License number

RES-000

Baltimore, MID

29d. Date signed (Month, Day, Year)

January 27, 2007

and manner stated.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Ami K. Mankodi 4940 Eastern Avenue

attending p

physician and s the burial-transf

Physician

/Medical

Examiner

Funeral

Director

r 28a-f shov notified at

"natural", or items 23a or

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Physician

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Certification: To

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with the Maryland

Baltimore, Maryland 21215-0036

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Part II. Other significa	int conditions	contributing to death but not re	sulting in the underlyi	ng cause	given in Part I.	. 2		se contribute to the car	use of death?
						. -	24a. Was an autopsy performed? ☐ Yes 2 No	24b. Were autopsy fi prior to complet death? 1 \(\text{Yes} \) 2 \(\text{\$\Bigsi}	ion of cause of
25. Was case referred	l to medical				26. Place of De	eath (Che	ck only one)		
examiner? 1 ☐ Yes 2 📉 No	•	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3] DOA	Other: 4 \(\sum \) Nursing I			XOther (Specify)	IOSPICE
2 Accident	5 Pending investigation		28b. Time of Injury M		njury at Work? I □ Yes 2 □ No	28d. [Describe how injury	occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place of injury - At h building, etc. (Spec	nome, farm, street, fa ify)	ctory, off	ice	28f. L	ocation (Street and ity or Town, State)	d Number or Rural Rou	ite Number,
29a. Certifier 1 (Check only one)	Certifying Promote Medical Example	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owłedge, death occu ation and/or investiga	rred at thation, in r	e time, date and plac ny opinion, death occ	ce, and d	ue to the cause(s) the time, date and	and manner as stated place, and due to the	cause(s)
29b. Signature and titl	e of certifier			29c. Lic	ense number		29d. Date	e signed (Month, Day,	Year)
•	-6			D	43725			1/24/07	
30. Name and address	s of person who	completed cause of death (Ite	m 23a) (Type, Print)					7	
DR. TARIO	MAHMOO	D 2300 DULAN 32. Ragistrar's Sign		RD.	TIMONIUM	, MD	21093		
J. Sale med (Werlan)	AN 3 0	2007 Mene	B. Span	A.S			.		

d State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #23b Per Sinte es saying properties of Desire and Mental Hygiene)

1- Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death TAMUARY Physician 2007 Ø6:20AM BETTIE L. HEINTZEMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) Center Examiner If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 □ M 2 💢 F Director 215-30-7005 1/18/1933 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits show notified at 1 ☐ Yes 2 No MD BALTIMORE PARKVILLE 28a-f Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any lighty or other traumatic event, the Medical Events 23a or 2 once. Funeral 8501-C DEMPSTER COURT 21234 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Marvland 21215-0036 Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COLLECTION AGENT BLACK & DECKER 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES H. HEINTZEMAN, JR. 2 EMMA ESTELLE JENKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES H. HEINTZEMAN, IV/NEPHEW 614 LORING AVENUE BEL AIR, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY: 1/27/2007 BROOKLYN PK, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death C HOURS Immediate Cause (Final ARRHYTHMIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) MYOCARDIAL INJURY Infarction Examiner 72 HOURS Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed CORONARY ARTERY DISEASE YEARS Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical attending p for use as 1 IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an page 2 s autonsy nerforme certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 Accident eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29c. License number 29b. Signature a 29d. Date signed (Month, Day, Year) D34543 athologist 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN R AXE. 7601 OSLER DRIVE M.D. TOWSON, MARYLAND 21204 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

JAN 3 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 730 **Physician** Ceceilia Hogan C /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Washington Birthblace (State or Foreign Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Prear Stown 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 059-03-5989 Director Flushing, NY June 11, 1912 Usual Residence of Decedent 10c. City, Town or Location the Maryland r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐Yes 2 ☐ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? o e Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene. 13319 Briarcliff Drive ral", or items 23a Examiner must b 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify. \$ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Chief Telephone Operator CIT Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Cambridge Emeline Fowler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan L Scobel/ Daughter 13319 Briancliff Dr. Hagerstown, Md 21742 Health tem 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or oth once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Howard University Jan18,2007 Washington, D C 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner IKKBBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner he law requires that the death certificate be executed THORO SCL BROTTE VACUURE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HOVER DONSION, ADRIAN FIRRILLADOM 1 Nes 2 No 3 Probably 4 Unknown Completed OBSMUCTUS PULMENTE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Medical Certification: 5 Pending investigation Injury 1 Natural 1 ∏Yes 2 ∏No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

1046622

19336 MEARON VIEW OR HAFORFORM MP 217112

Mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRNETT UZICAVIO

JAN 3 0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** HI KMOST 2:50 Elizabeth 200 an /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death
Catensville Examiner Villa lursin glerter Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jule 10 7. Age (In lyrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 201 Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? 5 Academ items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 To o
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore. Maryland 21215-0036 "naturei", or 1 Yes 2 No þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 is marked other then." College (1-4or 5+) Elementary/Secondary (0-12) Unknown 17. Father's Name (First, Middle, Last) Chatman Sam 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Phy Ilis daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pages 1 Department of H Important: if ite eny injury or ot once. 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine liate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death P.O. P 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 3 Probably 4 Denknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No To the Hospital or processing the state of the four selection of the Funeral Director. Alter this certificate has the funeral director, pege? autopsy performed? 2 🖸 No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 x Certifying Physician: To the best of my knowledge death obsided at the time, date and place, and due to the dause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 0 2007

32. Raistrar's Signatur

FILYS	cian		Amend #24a, perverbal. Amend #17,18, For Amend #1,2, pering a pe	ast) Mich	ael Cliff				2. Date of I	eath Ja	n, 11, 20	3. Time of Death
/Me	lical		Friendel He		nhor)		4b. Cib. Tour	a and ageting of Da	01	-10	9 07	L 5:35 A
Exan	iner		a. Facility Name (If not institution, given Morning Side Hol				Laur	n, or Location of De	atn		County of Dea	
Funera	al		. Social Security Number 6.	Sex /	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24 H		lirth	Prince (rthplace (State or Foreign
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s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or freme 23e or 28a-f show other traumatic event, the Medical Examinar must be notified at	Funeral Director		Oa. State 10b. County Naryland Prince G	eorges		ay, Town or Lo	ocation			,		10d. Inside City Limit
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tem 27		2	20a. Method of Disposition		20b. P	Place of Dispo	osition (Name of		Date	_	Location - City or	r Town, State
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State of Maryland / Department of Health and Mental Hygiene Amend #1 Per PHY G864 2/09/07 JH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Lee Davies Jay · LOUIS 1:15 AM VANUARY 27 2007 /Medical 4a Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Death Examiner BATTIMORE-5. Social Security Number (GENESIS) CONTER TON 8. Date of Birth (Month, Day, Year) if Under 1 Year It Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign
 Country) 6. Sex **Funeral** 1**X**M 2□ F Months Days Hours 242-66-9751 Usuel Residence of Decedent Yrs. North (wolina Director permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural; or hems 23a or 28a-f ahow 10c, City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f ahow traumatic event, the Macical Examinar must be notified at MD 1 Yes 2 No **Funeral Director** 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code ne . Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) anitation 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) harlie ပ Winston 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location 1 Seurial 2 ☐ Cremation 3 ARemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart tailure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequenca of): Physician/Medical Examine ettending physicien end for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. ERUBRO VASCI) ed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown cete hes been signed pege 2 should be del þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 Plio 1 ☐ Yes 2 ☐ No this certificete Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ⊟Naturel 1 Tes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1U certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) MEDICAL ATTENDING JANUARY 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) St Sure CHARLES 4202 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 3 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician ALBERT EMORY JACKSON, 10:15F M TANUARY 2007 26, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 5, 1938 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1**X** M 2□ F Months Maryland 68 216-34-0376 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State Abingdon 1 ☐ Yes 2 No Harford MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Unit_{2D} 21009 USA 203 Crosse Point Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. ☐ Yes 2 X No Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Receivables Consultants Inventor Elementary/Secondary (0-12) College (1-4or 5+) Executive Director Of Control Inc. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Cook Albert L. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21009 203 Crosse Point Court Unit 2D-Abingdon, Maryland Bonnie L. Jackson-spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial
Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1-30-07 1 DxBurial 2 □ Cremation 3 □ Removal from State Parkville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility 8800 Harford Road Parkville, Maryland 21234 EVANS FUNERAL CHAPEL AND CREMATION SERVICES Consuse h Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC PROSTATE CARCINOMA YEARS resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the following a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at 28d. Describe how injury occurred or Attending Injury 1 Natural 2 Accident 5 Pending 2 No 1 Tes investigation il Director: And in by the fr 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Mile 26-2007 0 D25886

State Registrar 30. Name and address of person who completed cause

JAN 3 0 2007

M. D

CEBALLOS.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

ORIGINAL

TOWSON MARYLAND 21204

f death (item 23a) (Type, Print)

OSLER DRIVE

1601

32. Registrar's Signature

			For State	State	of Marylar		artment of rtificate of				C.	007	02399	
	4		Registrar 1. Decedent's Name (First, Middle, L			001	timoato o	Dout		2. Date of De			3. Time of Death	_
	Physici /Medic		Ursula Agatha Ja	cobs						Month 01	25	200 7	11:29a ^M	
	Examin		4a. Facility Name (If not institution, g 3301 Hewitt Ave	_	imber)	ì	4b. City, Town, Silv	or Location er Sp			4c. C	County of Death Montgo		
100	Funeral Director		5. Social Security Number 6. 577-94-5190	Sex 1 □ M 2XIF	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Birl (Month, Da 11-15-	th 9. Birthplace (State Y, Year) Country) 1915 West In		nplace (State or Foreign untry) est Indies	
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits	_
	Maryla f sho	ţō	MD Mont	gomery			Silv	er Sp	ring				1 □Yes 2½QXNo	
	h the r 28a	Director	10e. Street and Number		1		10f. Zip Code						of What Country?	
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married ②☑Widowed 4 ☐ Divorced	Armed F	2 ∰No ive		. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ※XXNo Specify:					4. Race - Amer Black, White Specify: B1		
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121	within ene. than "	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use reti. emaker	red)			О	wn Home	9	
Baltimore, Maryland 21215-0036	id be filed ental Hygi ked other ic event, ti	To Be Co	17. Father's Name (First, Middle, La Sanford Reason	st)						(First, Middle, Gibson		Surname)		
Mary	and 2 shou alth and M 27 Is mar er traumat	-	19a. Informant's Name/Relationship Betty Jacobs/dat	(Type. Print) ighter		19b. Mailir 3301	ng Address (Stree Hewitt	et and Num Ave A	ber or Rura pt 30	l Route Numb 1 Silve	er, City or er Sp	Town, State, Z ring MI	¹ 20906	1
more	Pages 1 and of He		20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven 20c. Location - Cit										Fown, State	
Balti	21. Signature of Funeral Service Licensee M00382 22. Name and Address 933 Gist Av												ion Service	е
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or Vital Record	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detache	Completed								24a. Was auto perfo		24b. Were au prior to death? 1 ☐ Yes	topsy findings available completion of cause of	
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0	Physician: r this certificanal director,	P	1 ☐ Yes 2, 2, No 27. Manner of Death	1	Inpatient 2	ER/Outpatier 28b. Time o	" OLI DON			me 5 X Resi 28d. Describe		Other (Spec	cify)	_
on	Attending I r death. ector: After by the funer	tion	1XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	(Mo	nth, Day Year)	Injury	W	lork? □Yes 2[.,,.,	00041104		
Division	ء ۾ ٿے ⊑	Certification:	3 ☐ Suicide 6 ☐ Could not determine	∠oe, riac	e of injury - At h ding, etc. <i>(Spe</i> c	nome, farm, str	reet, factory, offic	e	2	28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C		aminer: On the			h occurred at the vestigation, in m							
	To the within 2 To the complete	29b. Signature and title of contifier 29c. License number H45839 29d. Date signed (Month, D 01-26-2007												
_	10		30. Name and addr ss of person will Gary E. Raffiel	d 5411	W Cedar	Lane #	Print) 202A Be	thesda	a MD 2	20814				
	Sta Regista		31. Date filed (Month, Day, Year)	2007	Registrar's Sign	ature	we							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician EDWARD** PRESTON JANNEY JAN 29. 2007 3:06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON HEALTH & REHAB FORT WASHINGTON PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) **Funeral** 1 x M 2 □ F 224 32 4280 Virginia Aug 6, **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Accokeek 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14716 Livingston Road 20607 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No Korean Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3√√Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 6th Oil Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Janney Maggie M. Gillispie ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie McAbee (Daughter) 2725 Butterfly Place, Indian Head, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial XXCremation 3 ☐ Removal from State Lee Crematory Jan 29,2007 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Alexandria Ferry Road, Clinton, MD art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** Thenosdenotic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an 2K No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 1 ☐ Yes 2 【No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01-24-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

MICHAEL SIDAROUS, M.D. 11701 LIVINGSTON ROAD, FORT WASHINGTON, MD 20744

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jerome A. Johnson State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 21, 2007 Medical Examiner 0059 hrs Jerome Α Johnson 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secour Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Foreign Months Days Hours Min Director 212-56-6069 1 X M 56 15 50 Country) MD Usual Residence of Decedent 10c. City, Town or Location ž 10a. State 10b. County 10d Inside City Limits MD NA Baltimore or items 23a or 28a-f show 1 X Yes 2 No notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21216 1910 Ruxton Ave U.S.A. Funeral 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Never Married 2 XMarried Armed Forces White etc. Yes Black If Yes, Give Year Widowed 4 Divorced 1 Yes 2 No specify: Specify: 'natural". Examiner ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lenent of Health and Mental Hygiene ant. If item 27 is marked other than "I cother traumatic event, the Medical I or other traumatic event, the Medical I Baltimore, MD 21215-0036 Laborer Various Jobs 10th grade na 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Evelyn Moreno Be George Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and N Important: If item 27 is m injury or other traumatic Rhonda Johnson-Wife Ruxton Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn 1/31/07 Baltimore Co, Md Donation 5 Other Specify Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, 21215 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and PII, penME, G864, 2/6/07 TT Physician/Medical X UNPENDED X AMENDED attending physician or use as the burial -#23a,PII,27,perME,g863, 1/31/07 TI Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed l ģ Chronic alcoholism narcotism 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 V Yes Residence 6 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c Injury at Work' 28d. Describe how injury occurred Certification: 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E January 21, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Physicia

/Medica Examine

Funeral Director

permit. Pages 1 and 2 s to Jd be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is rearked other than "natural", or items 23a or 28a-f show any injury or other trauments the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical

Division or Vital Records, P.O. Box 68760,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar	t	OIL	Jeain	Reg. No.									
an	1. Decedent's Name (First, Middle, Last) Elaine R.		Johansson 2. Date of Death Month JANUARY								Day Year 12:10 AM			
al er	4a. Facility Name (If not institution, give street and number	er)		4b. City, 1	Fown, or	Location	of Death	- TITULIA		4c. County of Death				
7	Baltimore Washington Medi	cal Cent	ter	Glen	Bur	nie			Arun	de1				
-	5. Social Security Number 6. Sex 7.	Age (In yrs. last b		Glen Burnie Anne A								Birthplace (State or Foreign Country)		
	022-03-8856 1□M 2XF	78	Yrs.	Months	Days	Hours	Min.	Jan. 1	ay, Yea	1929	Country) MA			
	Usual Residence of Decedent											11/11		
	10a. State 10b. County	10c. City, To	wn or Loc	ation							1	10d. Inside City	Limits	
jo	MD Anne Arundel	Glen I	Burni	e								1 ☐ Yes 2	No No	
rec	10e. Street and Number			10f. Zip	Code	-	-		10a C	itizen of \	What Cour	ntry?		
ō	1014 Cayer Drive			210					-					
al s			140.14				10/0			J.S.A. 14. Race - American Indian,				
Š	11. Marital Status 12. Was Decede Armed Force	s?	13. V	Yes, spec	ify Cuba	spanic Or n, Mexicai	n, Puerto	ecify Yes or N Rican, etc.)	10-		ck, White,			
Ϋ́	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give	X ivo	1	1 ☐ Yes 2 No Specify: Specify:							. W	hite		
g p	3 ☐ Widowed 4 ☐ Divorced Year or Date													
ete	15. Decedent's Education (Specify only highest grade completed)	16	a. Decedi <i>(Give k</i>	ent's Usual and of work	l Occupa k done o	ation <i>Juring mos</i>	t of worki	ing	16b.	Kind of B	Business/Industry			
MD Anne Arundel Glen Burnie 10e. Street and Number 1014 Cayer Drive 11. Marital Status 1 Never Married 2 Married Myers or Dates: 1 Never Married 2 Married Myers or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify: 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Myers or No-If Ye														
ō	Reservations Ai													
Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma										ne)			
ပ္	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State													
												Code)		
Mr. Charles Johansson /Husband 1014 Cayer Drive Glen Burnie, MD 21061														
20a. Method of Disposition 20b. Place of Disposition (Name of correctors and the place) 20c. Location - City or Town, State														
	1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Current School icensee 22. Name and Address of Facility Singleton Funeral Home 1 Second Avenue Sw Glen Burnie, MD 210 23. Point. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.												e. MD	
-														
	shock, or heart failure. List only one cause on each	sed the death. Do line.	not ente	r the mode	of dying	g, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between	een	
Н	Immediate Cause (Final disease or condition	PNOME	100	- TH	P	AN	22	+5 W	P17.	_		Inset and De	f	
	Immediate Cause (Final disease or condition resulting in death) a. CARCANOMA US TH PANCESTS USTTY Due to (or as a consequence of): MEMSTASES TO LAUR AND													
	Security list continues b. MEMSTASES TO LAUSE AND											WEEK	5	
ner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):													
Ē	that initiated events	H·NB	DES	•								WEEKS		
Ě		as a consequence	of):			,								
cal	d													
n/Medical Examiner														
Š	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes	ne pf pregnancy								234 Dat	te of delive	on.		
iar	in the past 12 months?	2 Fetal deat at time of death	th 3□I	Ectopic pre	gnancy					Mo		Day Ye	ar	
ysic	1 ☐ Yes 2 ■ No 9 ☐ Unknown 9 ☐ Unknown		30	Other (spe	~y/									
P	Part II. Other significant conditions contributing to death	but not reculting	in the un	derlying co	uso aivo	n in Dart I		23a Did	tobacco	uno cont	ributo to th	ne cause of dea	sth 2	
Be Completed by Physicia	4 00 10 1				-									
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e	25. Was case referred to medical	00,000	- [-1]	C // /	- / -/	26. Place	of Death	(Check only		9		20110		
0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa	atient 2 ER/O	utnatient	3 🗆 DO4	Othe	r.		ne 5∐Res		6 DO+	or (Coorie		-	
51	27. Manner of Death 28a. Date of le	njury 28b.	Time of		c. Injury Work			28d. Describe				7/		
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Ca	3 Suicide 6 □ Could not be	iniury - At home, f	arm. stre				_	28f Location	(Street a	nd Numh	er or Rura	I Route Numbe),	
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Ca	29a. Certifier (Check only (C	of examination a	ge, death ind/or inve	occurred a estigation,	ιι tne tim in my op	e, date an inion, dea	id place, a th occurr	and due to the ed at the time	e cause(: e, date ar	s) and ma nd place,	inner as st and due to	tated. the cause(s)		
ed ed	and manner	stated.						Т						
2	29b. Signature and title of certifier	1.	•		License		C 1			,		Day, Year)		
	1 Jan Kr	_ , ML	/	K	ノノ	77	7/		1/	25	120	107 Huzy		
	30. Name and address of person who completed cause o	f death (Item 23a)	(Type, P	rint)		• •	<u> </u>			/		1, 21	061	
	Drups Rose, M.D. SATTE	: 412 2	00)	HOSE	PM	ec. a	122	v2 6	CEA	BILL	2115	Hezy	LAIA	
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DHMH 17 Rev 1/2001

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Norman Jackson 01 /Medical 2007 5:30 D 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1510 West Mosher Street Baltimore If Under 1 Year | If Under 2 Months Days Hours 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 214-40-8533 Months Min. 1 M 2 □ F 68 Yrs. **Director** 10/23/1938 VA Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1510 West Mosher Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify African American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Willie Jackson ဥ Ella Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Hill / Daughter 1334 North Fulton Avenue; Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 01/30/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland emed 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinement cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a sunsequence off the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day ∫Yes 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy After this certificate performe 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner ath 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 2 To the

31. Date filed (Month, Day, Year) State Registrar

(Check only

29b. Signature and title of certifler

Medica

JAN3 0

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

LBENDE

and manner stated.



29c. License number

29d. Date signed (Month, Day, Year)

BALTOMO 2121

			1- For Amend #19a Per INF 8863 1/31/0	artment of Health and Mental I 7 Prtificate of Death	Hygiene 2007 02404						
	Dhusisi	*	1. Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death						
	Physici ->/Medic		John C. Kerr	Janua	ry 24, 2007 17:30 P ^M						
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
	- 1e		7879 Harold Road	Dundalk	Baltimore						
	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. (Month,	Day, Year) Country)						
Arriva man	irector		Usual Residence of Decedent	August	2,1930 Maryland						
land	ow at		10a. State 10b. County 10c. City, Town or L	ocation 10d. Inside							
Mary	De lied within 72 hours after death with the Maryland rital Hygiene. And there is no content then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ţ	Maryland Baltimore Dun	dalk	1 □Yes 2[XNo						
h the		Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
h wit		<u>=</u>	7879 Harold Road	21222	USA						
deat	er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							
after 2	or Ite			1 Yes 2 No Specify:							
215-0036 Ithin 72 hours af	ıral", I Exa	d by	3 Wildowed 4 Microsoft Year or Dates:	TE Tes 2 A No Specify:	Specify: White						
727	"natı	Completed	15. Decedent's Education 16a, Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry						
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iled N	nt, th		12 years Li 17. Father's Name (First. Middle, Last)	thographer	International Paper						
Vand Jid be file Aental Hy	ed o	Be C	John W. Kerr	18. Mother's Name (First, Middle Ester F. Moyer							
Maryland 2 12 should be filed v	mark	2									
Mar Id 2 sh	27 Is trau			ng Address (Street and Number or Rural Route Num Lodge Farm Road, Edgeme							
a - a	tem other		20a, Method of Disposition 20b, Place of Dispo		20c. Location - City or Town, State						
70 Pages	y or		1 Rurial 2 ViCramation 3 Romaval from State Cemetery, cre	matory or other place) January	Baltimore City, MD.						
altimor	ortar Inju			± 125, 2007	_,						
Der Der	Important: If Item 27 Is marked any Injury or other traumatic even		A futhory Connelly 7	2. Name and Address of Facility Onnelly Funeral Home Of 110 Sollers Point Road,	Dundalk, P.A.						
1	200 L		23a. Part1. Enter the disea e, or complications that caused the death. Do not en shock, or heart failure. Jist only one cause on each line.	ter the mode of dying, such as cardiac or respiratory	y arrest, Approximate						
Phy	sician		Immediate Cause (Final disease or condition	nd to head	Interval Between Onset and Death						
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uires	been signed by the should be detached	d by			☐ Yes 2☐ No 3☐ Probably 4☐Unknown						
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he la	this certificate has ral director, page 2	E.		24a. Wa	as an 24b. Were autopsy findings available prior to completion of cause of death?						
E ::	or, pa		25. Was case referred to medical	1□ Yes	3 2 2 No 1 Yes 2 No						
ysick	direct	To Be	examiner? 1 Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatier	26. Place of Death (Check only	y one) sidence 6 □Other (Specify)						
_ E	er th		27. Manner of Death 28a. Date of Injury 28b. Time of	Z Table 10 T	e how injury occurred ; /						
ath.	r: Aff	atio	1 □ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation 0 1 - 24 - 1007 1, 730	Work? 1 Yes 2 No Sall-	inflicted aumshot						
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s afte	ed in	Certification:	Home	7879	HAROLD RD. BALTO MO						
To the Hospital or Attending Physician: The law requires that the death certification after death.			29a. Certifier (Check only one) Check only one) Check only one) Check only one)	occurred at the time, date and place, and due to the	0.00000(0) and						
the h	the mplet	Medical	and mainer stated.								
Ā. ķi	2 8		29b. Signature and title of certifier T (40444m	29c. License number	29d. Date signed (Month, Day, Year)						
7	7	-	4 : 23/4407 ()	D000 7632	Junuary 25, 2007						
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, T. CRUSSAN O'DONOVAN, MD. 2112	DUNDALK AVE., BR	PLTO MD 21222						
175	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
·	Registra		JAN 3 0 2007 Below & Spe	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TILE#26, perPHYS. . 6863 1/30/07 to
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Marie Anna Koppenhaver 12:40 p M /Medical January 28, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Companions Asst. Living Taneytown Carrol1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 M 2 TF Director Yrs 218-28-3661 75 19, 1931 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23e or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23e or 28a1 ahow other traumatic event, the Model Examinat must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Locust Street Completed by Funeral 21157 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timothy Muchorowski ျှ Mary Kawecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 is Gary Rostkowski Son 8736 Lackawanna Avenue Parkville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser. 1/29/07 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ste 11824 Reisterstown Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Reisterstown, MD 21136 Approximate Injerval Between Olset and Death Immediate Cause (Final Physician CAI Chuo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day ned by the a 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3. robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home | Sidence 6 | Cher. | Appendix of the control of t P 1 ☐ Yes 2 No To the Funeral Director: After the completely filled in by the funeral 27. Manny of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending death. 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 30. Name an address of person completed cause of death (Item 23a) (Type, Print) 3 555 South Castar Straot Wastur Star, MD MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year а м 6:15 Kendrick 27, 2007 Μ. January Russell 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Reisterstown Futurecare Cherrywood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Hours Days 1 XM 2 ☐ F June 10, 1911 95 Maryland 215-03-3624 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Pikesville <u>Baltimore</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 8406 Prarie Rose Place 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23© No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Novidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ranzell I. Kendrick Cora L. Yoonts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8406 Prarie Rose Place Pikesville, MD 21208 Alice Wood Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 2/3/07 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road te gukins ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotiz Cordiovascular disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cardiomy apathy, chronic renal failure 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? of colon concer with recent lower gastro intestinal bleed 2 No 1 Tyes Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending 1 Yes 2 No М investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO058676 January 30, 2007 Haven R. Balrit, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main street, stite 200 Reisterstown MD 21136 KOMA L. Babitt, M.D.

State Registrar

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Itame 23s or 28s-1 ehow any injury or other treatmetic event, the Medical Examinat must be notified at appear.

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To the Funeral C

completely filled

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

Baltimore, Maryland 21215-0036

JAN 3 0 2007

31. Date filed (Month, Day, Year)

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 27, 2007 **Physician** 2:29 А м Elizabeth Faith Keniston January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 7, 192 9. Birthplace (State or Foreign Country) Nebraska 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 84 474-18-4629 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Derwood Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20855 17805 Cliffbourne Lane United States by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc.
White 1 ☐ Yes 21公 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 Ho 3altimore, Maryland 21215-0036 Specify: 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery County al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Librarian Libraries 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Eva Jo Cook Rolf D. Toness 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 803 Philadelphia Avenue, Silver Spring, MD 20910 Gregory Keniston/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition February 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2, 2007 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M00092 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Embolism u morary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner veuous URCS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Imo. Neu no NI burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician > Emen fi Physician/Medical the as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 mpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i *Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Chludenes, M.D. 15825 Shady POCKNILLE M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khly denen Konstantin 32Registrar's Signature 31. Date filed (Month, Day, - Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 28, 2007 Physician Dale David Krolicki 8:07a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Brinton Woods Health Care Center Sykesville 6. Sex **XX**M 2□ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | April 18,1933 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 73 Ohio 216-28-4235 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes XXNo Director Hampstead MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 U.S.A. 4017 Sharecropper Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black White etc. 1♥ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes XXNo Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Planner Lockheed Martin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wanda Krolicki Edward Krolicki ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4017 Sharecropper Lane, Hampstead, MD 21074 Nova Krolicki / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 1/31/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 21. Signature of Pineral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4KTIRIUSCLE ROTIC uliapt /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last 15CHOMIC Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 1 No 1 ☐ Yes 2 ☐ No 1∐ Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I 29c. kicense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

MIRICK 31. Date filed (Month, Day, Year)

JAN 3 0 2007

1000 LIBERTY RD FLDERSBURG WD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1UANS UD

32. Registrar's Signature

Konaid Joseph Le		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2	07 021.0										
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Janes J.		4a. Fability Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of I Baltimore											
Funeral Director		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9	9. Birthplace (State on oreign										
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r death with the Maryland or items 23a or 28a-f show any must be notified at once.		10a, State 10b. County BAITIMORE	10d. Inside City Limits 1 es 2 No										
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	Stry										
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\ 7		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	-										
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			State of Maryland / Department of Health and Mental Hygiene	
			1- For State State Registrar Certificate of Death Reg. No. 2007 024	0
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	h
	Physici		Marcellus Vincent LaFleur, III Jan. 27, 2007 21:20	M
1	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	_Xuiiiii		Carroll Hospital Center Westminster Carroll	
-	Funeral			e <i>ign</i>
Ы	Director		5. Social Security Number 218-80-6331 6. Sex 7. Age (In yrs. last birthday) 1 I I I I I I I I I I I I I I I I I I	
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36	rs af L', or xami	by F	1 □ Never Married 2 M Married 1 M Yes 2 □ No If Yes, Give 1 □ Yes 2 No Specify: Specify: White	
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	ed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	
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Ja	should be and Mental semarked or umatic eve	To E	Marcellus Vincent LaFleur, Jr. Beverly M. Greene	
Maryland			19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
S	1 and 2 Health tem 27 I		Mrs. Theresa L. LaFleur (Wife) 617 Shimmering Run Ct., Sykesville, MD 21784	
ore	ges 1 au it of Hea if item or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State	
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Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400	
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	To t To t Com	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
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_	10		30. Name and address of person who completed cause of de th (Ir m 23a) (Type, Print)	
	10		CHARLES HENSGEN 4TO MALCOLM DRIVE WESTMINSTER MD 21	15
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #10c Per TH G863 1/30 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Heinrich Joseph Losemann Jan. 28,2007 6:20 /Medical а 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Ctr.for Hospice Care Gilchrist If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1∏M 2□F 219-38-7151 79 Sept.18,1927 Director Germany Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Timonium Md. Baltimore 12240 Roundwood Dr 1 □Yes Z□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12240 Roundwood Rd. Unit 303 death v 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or have any Injury or other trainment. 1 ☐ Yes 2 No If Yes, Give 2 No Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Anesthesiologist 12 Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhelm Losemann Anna Hessmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12240 Roundwood Rd. 303 Timonium, Md.21093 Christel Losemann -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 25 ☐ Other (Specify) Metro Crematory Jan. 31, 2007 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21117 23a. Part. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Owings Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** ear /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9□Unknown 9 Unknown sate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform rmed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUAY 28,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Nr. Charles St. Balto md Rile 21205 6 BMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** RUTHLEE В. MCMAHON **JANUARY** \mathbf{A}^{M} 24 2007 7:10 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Healthcare of Laurel Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 K F 579-28-5482 Director 82 July 4, 1924 Washington, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show dic: I Examiner must be notified at 1 ☐ Yes 2X No Director MD Prince George's Laurel the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15709 Bond Mill Road 20707 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 20XNo ò Specify: Specify: 3€Widowed 4 □ Divorced White Completed the Medic: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) oe filed within 7 al Hygiene. i other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be h and Mental James R. Bailev, Sr Edna L. Owings ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i James R. Bailey, Jr. /Brother 15709 Bond Mill Road, Laurel, MD Department of Healt Important: If Item 2 any injury or other once. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/26/2007 Suitland, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Five the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line.

Immediate Consecution. Approximate Interval Between Onset and Death **Physician** Acute Pulmonary Embolism disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I ed by the a detached 1 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Peripheral Vascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 [X]No page 2 s autonsy performed' 1□ Yes 2 ₩ No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 ☐ Pending investigation XXNatural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide hin 24 hours at Hospital 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0053235 January 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 13635 Baltimore Avenue, Laurel, MD 20707 Darryl Hill, MD 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State JAN 3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Marciszewsk ecilia mulmy 2) 200) /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** Wom Nursin 8. Date of Birth (Month, Day, Year) Dec. 11, 1918 5. Social Security Number Age (In If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🔀 F Hours Maryland 213-03-9326 88 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Parkville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3209 Hiss Avenue 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify 2 Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed ww.

Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) At Home permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other two contracts. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Kurowski Constance Doliwa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3209 Hiss Avenue-Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type. Print) Anthony Marciszewski-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1 - 30 - 07Dundalk, Maryland Holy Rosary Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8800 Harford Road Parkville,MD 21234 EVANS FUNERAL CHAPEL AND CREMATION SERVICES 4dd -endral 441 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhama **Physician** 1 acc ara disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): signed by the attending physician dbe detached for use as the buria Physician/Medical Box IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Inknown Completed been pertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate Division or Vital 1∐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death To the Hospital or Attending Pwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c, License number 5 and address of pers who completed cause of death (Item 23a) (Type, Print) GAO JAN 3 0 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear William Elwood Minton 2007 3:40 P /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1∏M 2∏F Director 214 44 6137 60 Aug 5, 1946 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1054 North Marlyn Avenue 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 X Yes 2 No If Yes, Give Year or Dates: 1967–69 1 ☐ Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 Widowed 4 Divorced the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Chemical Technician</u> Chemical Company Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, ti once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ((unknown) Minton 2 Sadie Layton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Minton (wife) 1054 North Marlyn Avenue Essex Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Bayview Crematory Inc 01/29/2007 Baltimore, Maryland 4 □ Donation 21. Signature of Fundral 5 rvice Licen 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part1. Enter the disease, or co Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 0

DHMH 17 Rev 1/2001

N. Charles St.

no

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 27, 2007 **Physician** 7:40 P M Mazzurco Esther May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Nursing Home Essex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 8, 1933 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 💢 F 72 213-30-2003 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore Middle River Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 Grovethorn Road 21220 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Custodian 12 should be filed w h and Mental Hygiel 7 is marked other th School Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sam Mazzurco Jennie Barnett ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Nancy Seitz Friend 12920 Community Drive, Middle River, MD. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any Injury or otl January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk,MD. 30, 2007 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21. Signature of Fugeral Service Licens wthony complications that caused the death. only one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. melastases Immediate Cause (Final Canby, **Physician** Un-known disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bading to infinite actions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-transi and Due to (or as a consequence of) Box 68760, Physician/Medical as ding 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>۾</u> ↑ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 21 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending 1 Natural 2 Accident s after dea. Injury 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Registrar DHMH 17 Rev 1/2001

the Hospital of thin 24 hours at within 24 hours a

To the Funeral C

completely filled i

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M-D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALICA WASCEM. FO 9. BAS-

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

709. BASTERN BWD.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D-38754 29d. Date signed (Month, Day, Year) 01-29-2007.

M-D-21221

			1 - For State Registrar	State of Marylan	•	artment of I		d Mental	Hygiene	2007	02416
7	Physici /Medio Examir	àl	1. Decedent's Name (First, Middle, Last Carla 4a. Facility Name (If not institution, give	Joann	41		dock		of Death Da URY &		3. Time of Death (430 a.M
	Funeral Director		Usual Residence of Decedent	□M 212 40	Yrs.	If Under 1 Year Months Days	If Under 24 Hours		i, Day, Year)	9. Birth Cot	nplace (State or Foreign untry) MD
	the Marylan 28a-f show	ector	10a. State 10b. County MD Baltiπ 10e. Street and Number		y, Town or Lo	allstow	n		10g Ci	tizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
(0	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, Ira Madical Examinant rulal 2a mallied at ance.	Funeral Director	8523 Glen Micha 11. Marital Status 12 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ Xio	.S. 13.	Was Decedent of If Yes, specify Cub		? (Specify Yes o uerto Rican, etc		U.S.A 14. Race - Amer Black, White	ican Indian,
21215-0036	thin 72 hours a e. en "natural", o Madical Exer	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	If Yes, Give Year or Dates: fucation de completed) College (1-4or 5+)	16a. Dece	1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retire	pation	working	16b. k	Kind of Business/I	Black
Maryland 21	ould be filed wi Mental Hygien arked other th atic event, the	To Be Con	12th grade 17. Father's Name (First, Middle, Last) Harry Murdock S			Cashi	18. Mother's	Name (First, Mi		Deli n Sumame)	
	os 1 and 2 sho of Heelth and f item 27 is mv r other traumer		19a. Informant's Name/Relationship (Derrick Colbert 20a. Method of Disposition ℃Burial 2 □Cremation 3 □	-Friend	8523	Glen Mosition (Name of matory or other pla	ichael	Lane,	Ran	dallsto	own, Md
Baltimore,	permit. Peg Depertment Important: i any injury o		4 Donation 5 Other (Specification 2)	1)		armel Name and Addr ACCh Wab		/30/07 - 7e, Ba]		ltimore re, Md	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a. Advance Due to (or as a conseq	L M	le tasto	ng, such as car Atie	1	ory arrest,	-	Approximate Interval Between Onset and Death
8760,	the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of):						
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3[□Ectopic pregnand □ Other (specify) _	y			23d. Date of deli	very Day Year
	iaw requires that the as been signed by th 2 should be detache	b	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	ınderlying cause gı	ven in Part I.			use contribute to	the cause of death?
Vital Records,	en: The law i lificate has b lor, page 2 sh	e Completed	25. Was case referred to medical				26 Place of			prior to death?	topsy findings available completion of cause of
of	To the Hospital or Attending Physicien: The I within 24 hours after death. To the "unerel Director: After this certificate his completely filled in by the funeral director, page	To B	examiner? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time of Injury	of 28c. Inju	her: 4 Nursir	ng Home 5 🗆 28d. Desc		6 □Other (Spec	cify)
Division	Hospital or Atter 44 hours after de Tunerel Directo	i Certification:	3 Suicide 6 Could not b determined	building, etc. (Special	(y)			City o	r Town, Stat	re)	ral Route Number,
	To the Hos within 24 ho To the Fun completely t	Medical	29a Certifier 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	ation and/or in	ivestigation, in my	opinion, death o	occurred at the t	ime, date an	ate signed (Month	to the cause(s)
)	2			completed gause of seath (Iter	n 23a) (Type	Print)	8955	7	1	124/07	7
	Sta Regist		31. Date filed (Month, Day, Year)	82. Registrar's Signa	ature	le le	V- 011	CERTAL	146	of lace	

07-00717

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Miller, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day January 25, 2007 **Medical Examiner** WILLIAM J. MILLER, 1916 hrs JR. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 916 S. Highland Avenue Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) MD Months Days Director Hours 219-50-2742 1X M 2 F 59 11/17/1947 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Y Yes 2 No MD N/A BALTIMORE 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country 916 S. HIGHLAND AVENUE 21224 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 X No Yes 1 Yes 2 X No specify 3 Widowed 4 Divorced If Yes, Give Year Specify: WHITE þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than MAINTENANCE BALTIMORE CITY Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be WILLIAM J. MILLER, SR. **VERA** BETCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD GERARD MILLER/ BROTHER 1101 PEACHTREE ROAD, FALLSTON, MD 21047 permit Pages 1 and 2 Department of Health 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore. 1 X Burial 2 Cremation 3 Removal from State crematory or other place) mportant: 4 Donation 5 Other Specify. MT. CARMEL CEMETERY 1/29/07 BALTIMORE, MARYLAND 21. Signature of Eugeral Service Licenses 22. Name and Address of Facility
LILLY & ZEIL
700 S. CONKL ZETLER INC. FUNERAL HOME CONKLING STREET, BALTO., MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Deep Venous Thromboses Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED Box 68760 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy past 12 months? Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ⋧ Hypertensive cardiovasculardisease 1 Yes 2 No 3 Probably 4 Unknown Completed | 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical Be 26 Place of Death (Check only one) Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other Scene 1 V Yes 28a. Date of Injury (Month, Day,Year) Unknown

Division of Vital Records, Physician: After this To the Hospital or Attending

27. Manner of Death

Natural

Suicide

Homicide

29b. Signature and title of certifie

2 🗸 Accident

Pendina

Investigation

Could not be

'0°'2007

Certification:

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature

West 5.1

and manner stated

(Specify) Townhouse / Rowhouse

28b. Time of Injury

Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work

29c. License number

O.C.M.E.

1 Yes 2 V No

28d. Describe how injury occurred

or Town, State) 916 S. Highland Avenue, Baltimore, MD

28f. Location (Street and Number or Rural Route Number, City

January 26, 2007

29d. Date signed (Month, Day, Year)

Recent fall down steps

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25, 10:22 PM Djehanguir Mehrabanzad January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 12201 Coppola Drive Montgomery Potomac If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 3, 1928 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2 □ F Hours Country) 78 Iran Director 213-02-1065 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Marylan Hygiene.

Other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 12201 Coppola Drive United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Iran Air Force and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Azizallah Mehrabanzad Soraya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Soheil Mehrabanzad/Son 12201 Coppola Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 28, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature Funeral Service Licensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myeloid Leukemia 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the crying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Hospital or Attending Physician: after death.

I Director: After this d in by the funeral d filled in by within 24 hours a To the Funeral

3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29c. License number

D0047348

29d. Date signed (Month, Day, Year)

2007

Jan 26,

Medical

Kun MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Douglas Smith, M.D. 1650 Orleans Street, Room 246, Baltimore, Maryland 21231

State Registrar

29b. Signature and title of certifier

\$2. Registrar's Signature

State Registrar

ARNOLD MEGIL

29a. Certifier

(Check only one)

29b. Signature and title of certifier

filed (Month, Day, Year)

Medicai

completely

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Monthy Day, Year)

The law requires that the death certificate be executed 28, P.0. or Attending Physician: WILLIAM ot Division

2007

JANUARY

MARTIN

Funeral

Director

in than "neturel", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at

If item 27 is marked other or other traumatic event,

permit. Page Department of Important: If eny injury or once.

and

physician

à

certificate

After this

Director:

death.

s 1 and 2 should be fill Health and Mental H tem 27 is marked off

Pages 6

filed within 72 hours after death with

21215-0036

Maryland

Baltimore,

Physician /Medical Examiner for use as the burial-transit page 2 should be uneral director. Certification: To the 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direct completely filled in by determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24142007 Janvan NOS 141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

IAN 3 0 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ERNESTINE WRIGHT,



TIMONIUM, MD 21093

			1 - For State Registrar	State of Maryla		artment of H		Mental Hygien	21111	02421			
13	DECEMBE.		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month D	ay Yeer	3. Time of Death			
	Physicia /Medic		Elizabeth	Lewis	Mosher			Jan 0	2 2007	1415 P M			
1	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, or			c. County of Death				
.63	<u></u>	78	Holy Cross Hos 5. Social Security Number		rs. last birthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.		Montgomer	ry place (State or Foreign			
	Funeral Director		480-14-1110	1□M 2XF 9(Months Days	Hours Min.	(Month, Day, Yea 09/15/19	r) Cou	Creek, Iow			
P	- AL		Usual Residence of Decedent			<u> </u>		1 09/13/19					
ırylan	whow det	_	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits 1,□XYes 2 □ No			
e Mi	Se-f.	Director	MD Montgo	mery	Silver			142-6					
with t	B or 2	ā	10e. Street and Number	D4 V=+ 303		10f. Zip Čode			itizen of What Cou	intr y ?			
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ofter d	r the	Fu	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ☑ No		Was Decedent of Hi If Yes, specify Cuba		o Rican, etc.)	Black, White,	_			
Surs a	Exam	٩	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 2 X ☐ No	Specify:		Specify: WI	nite			
ZIZIO-0030 od within 72 hours aff	nete Hear	Completed	15. Decedent's (Specify only highest		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king 16b.	Kind of Business/Ir	ndustry			
vithic A	han a Ma	m	Elementary/Secondary (0-12)	College (1-4or 5+)		ecretary)		ne White	House			
Q Z I Z I 3-UU30 filed within 72 hours after death with the Maryland	Hygie ther t		12 17. Father's Name (First, Middle, La	lst)			18. Mother's Nan	ne (First, Middle, Maide		110 40 0			
E Pa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Department of Healin and Mental Hygiene. Service than "returned to the than" natural; or items 23a or 28e-f show sny injury or other treumatic svent, the Medical Examinar must be notified at QDGs.	To Be	Daniel J Lewis				Mary	Wake Lewi	5				
Maryland od 2 should be file	is ma		19a. Informant's Name/Relationshi					lral Route Number, City lver Spring					
1 and	Health Brm 27 ther t		20a. Method of Disposition	J Ma. 209 Location - City or T									
BAITIMOFE , permit. Pages 1 a	nt of 1 :: # its		1 Burial 2 Cremation	□ Hemovai nom State		osition (Name of matory or other place							
	ortani injury		4 ☑ Donation 5 ☐ Other (Specify) Howard University 01/03/2007 Washington, D 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Ho										
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oo rou, ifficate be executed		dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Right B Due to (or as a cons	reast C	ancer							
death ceri	e attending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time (□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year					
S, T	been signed b should be deta		Part II. Other significant condition	s contributing to death but not	resulting in the u	inderlying cause give	en in Part I.			the cause of death? bably 4 \textstyUnknown			
VITAI MECOLO sician: The law require	is certificate has been director, pege 2 shoul	Completed						24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of			
Attending Physician:	certifi. ector,	Be	25. Was case referred to medical examiner?	Hospital:		ot all post Othe	ar	ath (Check only one)					
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UI.	within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the	To t	Σ	29b. Signature and title of certifier		10	29c. License			ate signed (Month,	, Day, Year)			
}			Klon	M	1		54189	1/	3/07				
•	30		30. Name and address of person w	no completed cause of death (Item 23a) (Type,	Print)							
-	Sta	ato	Rama Kapoor 31. Date filed (Month, Day, Year)	MD 1500 F	orest G	len Rd. S	ilver Sp i	ring, Md 20	910				
	Registr		IAN 3 0 2	MD 1500 F 32. Registrar's Si	s. Apr	We I							

DHMH 17 Rev 1/2001

07-00625 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Diane Mae Odom State of Maryland / Department of Health and Mental Hygiene 2007 02422 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) Oueenie Odom 2. Date of Death Physician/ Month Day January 22, 2007 Medical Examiner 1825 hrs Diane 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 13108 Briar Cliff Terrace Germantown Montgomery 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreiar Days Director 12 26 53 Country) 53 VA 225-82-2831 M 2 X F Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Yes 2 X No Germantown 28a-f show MD Montgomery s 23a or 28a-f shov e notified at once. hours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S.A. 20874 13102 Briar Cliff Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 12. Was Decedent Ever in U.S. must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X No Yes Black Yes 2 X No specify 3 Widowed Divorced If Yes, Give Year Specify ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 in nent of Health and Mental Hygiene. 21215-0036 CPA 12th grade na Accounting 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Washington Queen Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clovis Ave, Capital Heights, Md 20743 James Washington 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State timore, crematory or other place) X Burial 2 Cremation 3 Removal from State Important: I Washington Family Emporia, VA 2/3/07 Other Specify Donation 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death a. Multiple Blunt and Sharp Force Injuries and Asphyxia Immediate Cause (Final disease) Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X AMENDED #1 UNPENDED attending physician or use as the burial g864. perME, Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ σ. 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✔ Yes 2 2 No 25. Was case referred to medica 26. Place of Death (Check only one) the Hospital or Attending Physician: of Vital Be Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes No 28a. Date of Injury FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject assaulted FOUND: Division Natura Yes 2 V No Pending Director: the 1822 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 13108 Briar Cliff Terrace, Germantown, MD within 24 hours a determined (Specify) Residence 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 23, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Year WILLIAM JAMES PAZDERA an 2007 ham /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Examiner osedale Franklin Square 105 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Ag (In yrs. last birthday) **Funeral** Days Min 10XM 20 F Hours 212-34-4714 69 Director Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits ?7 ie marked other then "naturel", or Heme 23a or 28a-f eho: treumatic event, tre Modical Examiner must be notified at MD Baltimore Parkville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9009 Harford Road 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Cable Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ludwig Pazdera Marie DeOms 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9009 Harford Road-Parkville, Maryland 21234 Catherine Pazdera-spouse 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H importent: if its eny injury or oti ong injury or oti cemetery crematory or other place)
Holy Redeemer
Cemetery 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-1-07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville,MD 2123 22. Name and Address of Facility maine 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death av **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) the per 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 No 1 ☐ Yes 2 ☐ No 1 Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ▼No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA ctor: After this y the funeral of 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death within 24 hours efter de To the Funerel Directo completely filled in by th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Jan 28, 2007 10

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 3 0 2007

Bengson 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25, 200 **Physician** Month Voyd G. Palmer anvar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Samar 1109 ortal 8. Date of Birth (Month, Day, Ye If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age #n yrs. last birthday) Birthplace (State or Foreign Country) Year) 1917 Funeral Days Hours 1**∑**M 2□ F 227-10-7008 89 Director Va, Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Md. Baltimore Dundalk 1 □ Yes 2 No Director 28a-f 7132 Railway Ave. 10f. Zip Code 10g. Citizen of What Country? 21222 items 23a or USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. TYTYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ٥ 1 ☐ Yes 2 No Specify: White Specify à 3 Widowed 4 Divorced Maryland 21215-003 "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Steel Mechanic 12 should be filed w h and Mental Hygier 7 is marked other th 9 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jefferson D. Palmer Mary Bell Shinault P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar. Important: If Item 27 is r. any injury or me. Beulah Palmer wife 7132 Railway Ave. Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 29 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cem. Parkville 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licens 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-trans and Due to (or as a consequence of) Box 68760, attending physician pe Physician/Medical HYPERIENSION IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy PERIPHENAL 1∐ Yes 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deat Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home P 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 🗆 No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

P.0. Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director,

State

31. Date filed (Month, Day,

29b. Signature and title of certifie

ted cause of death (Item 23a) (Type, Print)

5601 LOCIT RAVEN SLV1

Registrar's Signature

Registrar

State

Registrar

1386L)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

TARIO MAHMOOD

<u>JAN 3 0</u>

31. Date filed (Month, Day, Year)

	1 - For State Registrer	State of M	aryland / Dep <i>Ce</i>	artment of rtificate or		nd Mental Hy	/giene	0.7	02426
Physician	1. Decedent's Name (First, Middle		ssell			2. Date of D Month	eath Day	O ^{Year}	3. Time of Death 6:59 PM
/Medical Examiner	4a. Eacility Name (If not institution	n, give street and number)	() / .	// .	or Location of		A	nty of Death	
Funeral	5. Social Security Number		e (In yrs. last birthday	If Under 1 Yea			irth	9. Birthpla	ace (State or Foreign
Director	218-01-5202 Usual Residence of Decedent	1 ∰M 2□F	85 Yrs.	Months Day	S Hours	4-22-		Mary	
death with the Maryland rms 23e or 28a-f show rough be notified at neral Director	10a. State 10b. County Maryland N	/A	10c. City, Town or L	ocation altimore	<u> </u>			100	d. Inside City Limits ▼X Yes 2 □ No
vith the Ma	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Countr	
offer death with the relation of the relation	2070 Druid P	ark Drive	Ever in U.S. 13.	Was Decedent of	212 Hispanic Orig		o- 14. P	USA Race - American	
ICL Z IZ ID-UU30 If yelled within 72 hours after death with the Marylan I Hygiene. other then "neturel", or items 23e or 28e-1 show yent, if w Modical Exemit er must be nutified at the Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No	If Yes, specify Cu 1 ☐ Yes XX N		in? (Specify Yes or N Puerto Rican, etc.)		Black, White, et white	
II Z I Z I D-UU30 Ilied within 72 hours after Hygiene ther then "neturet; or lie nnt, the Malical Exemits Completed by Fu	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)	(Give	edent's Usual Occ e kind of work don DO NOT use reti	e during most red)	of working	16b. Kind of	f Business/Indu	istry
be filed will half be filed will half hygien of other the event, the beauth.			Fa	ctory wo		's Name (First, Middl	Assem		
≓ gase = m	TT-1					e Parsley			
2 n E N 2	19a. Informant's Name/Relations Katherine Durne			-		or Rural Route Num. ive Balti			
baltimore, r permit. Pages 1 and Department of Healt Importent: If item 2; any injury or other 1	20a. Method of Disposition 1 XXurial 2 ☐ Cremation		20b. Place of Disp cemetery, cre	osition (Name of matory or other p	lace)	Date	20c. Locatio	on - City or Tow	n, State
mit. Pa mit. Pa partmen sortent: / injury 29.	* 4 □ Donation 5 □ Other (5 21. Signature of Funeral Service	·- , - · ·	, at Garr	ison For	est 1	ery 1/31/0		ngs Mill	Ls, MD
Per Employer Control of Control o	23a. Part1. Enter the disease, o	4 Capit	the death. De sat as	Burgee-H 3631 Fal	lenss-Se	eitz Funer 1 Baltimo	al Home re, Mar	Inc.	21211 Approximate
Physician /Medical	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	only one cause in each li	ardial	Infa			arrest,	1	Interval Between Onset and Death
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executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
D Pur De D	that initiated events resulting in death) Last	cDue to (or as	a consequence of):						
certificate oding physise as the		d							
D - 2 - 2	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnar □ Other (specify)				Date of delivery Month D	y Day Year
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The fav						aut	opsy formed?	prior to comp death?	sy findings available pletion of cause of
VIC sicien scertifi irector	25. Was case referred to medical examiner?	Hospital:	ent 2 ☐ ER/Outpatie	art 30 DOA	Mar	of Death (Check only		Other (Co/f.)	
ng ng ng ng ng ng ng ng ng ng ng ng ng n		28a. Date of Inju	ry 28b. Time	of 28c. In	jury at fork?		how injury occ		
DIVISION Control of the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After tompletely filled in by the funeral Medical Certification:	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 286. Place of In	jury - At home, farm, s cc. <i>(Specify)</i>		∏Yes 2∏N e	28f. Location	(Street and Nu own, State)	mber or Rural i	Route Number,
lospitel hours a unerel I	29a. Certifier 1 Certifyi	ng Physician: To the best Exeminer: On the basis of	of evamination and/or i	avactication in m	u opinion deatl	b occurred at the time	data and place	an and due to t	the equipm(a)
o the Hosp vithin 24 hour o the Funer ompletely fil	one) 29b. Signature and title of certific	and manner st	ated.	29c. Lice	nse number		29d. Date sig	gned (Month, D	ay, Year)
->-0	· alleim	in MD		AU4	176435	W17471	Janua	ry 28,	2007
5+	30. Name and address of person ASNIEY WE	who completed cause of a	death (Item 23a) (Type	V. GRER	we St	Reet BA	Ltimor	e, MD.	21201
State Registrar	31. Date filed (Month, Day, Year JAN 3	and manner st and manner st MD who completed cause of the completed cause of the completed cause of the completed cause of the complete cause of the cause of the complete cause of the	rar's Signature	uls)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** 23 2007 TUKEARY Larry Bala Rivera /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Dea Examiner 4c. County of Death GLEN BUZNIE BALTIMORE WASHINGTON MEDILAL CENTER ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Director **218-35-205**0 2. 1927 **Phillipines** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits MD **Funeral Director** Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 248 Mack Intosh Drive 21061 Phillipines 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify ģ Specify: Filipino 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Photographer Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calixto Rivera Emeliana Bala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Bala Rivera - Son 248 Mack Intosh Dr., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State HBurial 2 Tremation 3 P 4 Donation 5 Other (Specify) 3 □Removal from State 4 Donation West Arundel Crematory 1-27-2007 Odenton, MD aneral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METACTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No hours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the of certifier 29c. License number Mi ddress of person who comp Name and eted cause of death (Item 23a) (Type, Print) Cenbarnie HOCPITAL 31. Date filed (Month, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 7 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 27, Michael Francis Ronguest 6:35 PM January 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Pasadena Anne Arundel 7805 Notley Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 XM 2 □ F Yrs. Director 498-44-1247 64 12-28-1942 MO Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2√2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7805 Notley Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelih and Mental Hygiene. Important: if item 27 is marked other then "na any injury or other traumatic even" (Give kind of work done during most of working life. DO NOT use retired) Industrial Air College (1-4or 5+) Elementary/Secondary (0-12) Conditioning Structural Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley C. Ronquest Sr. Eleanor McBrady ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia A. Ronquest/Wife 7805 Notley Road Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2007 St.Louis, Missouri 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service License 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of the such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 705 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ②X No 1 ☐ Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 41 completed cause of death (Item 23a) (Type, Print) 0 32 Registrar's Signature 1. Date filed (Month, Day, Year) State JAN 3 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** anuary 25, 200 05 am Maxine E. Rawley /Medical 4a. Facility Name (If not institution, give street and number) J4c. County of Death 4b Gity, Town, or Location of Death Examiner Ott N/A Age (In v If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 □ F Hours 216-34-9559 Director May 12, 1936 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f sl must be notifled 1 XYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Eutaw Place - Apt. 808 21217 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or item: ledical Examiner n Black, White, etc. filed within 72 hours after 2 No ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify. Completed by If Yes, Give Year or Dates: Specify 3 ₩Widowed 4 ☐ Divorced Black other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be and Mental ဥ George Henson Elizabeth Henson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 4121 Granada Avenue Baltimore, Maryland 21216 Gail Carter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö □ Surial 2 □ Cremation 3 □ Removal from State Department climportant: If any Injury or 4 Donation 5 Other (Specify) 01/31/07 Baltimore, Md. Woodlawn Cemetery & Chapel 21. Sign Ja 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner I or AttendIng Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the Unread director, page 2 should be detached for use as the burlansit in by the Unread director, page 2 should be detached for use as the burlan-transit that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 12 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	State o	f Maryla	and / De	epartmer Pertification	nt of H	ealth a Death	nd M	ental Hyg	iene (7	0243	30
Physicia	n	Decedent's Name (First, Middle,	,	ueen :	Shaba	72				2. Date of Deat Month Jar	2 ⁰ , 2007	Year	3. Time of De 1705	eath M
/Medica Examine		4a. Facility Name (If not institution,		mber)			Town, or	Location of	Death		4c. County			
Funeral Director		218-70-5710	6. Sex 1 ☐ M XX F		rs. last birtho	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Apr 18,	1959		hplace (State or Fi	oreign
aryland ehow	٦	Usual Residence of Decedent 10a. State 10b. County	N/A	10c.	City, Town o	r Location	Bah	timore					10d. Inside City L	
th the M or 28a-f	Sirecto	Maryland 10e. Street and Number				10f. Zi	Code			10	10g. Citizen of What Co			
in Z 1 Z 13-UU30 filed within 72 hours after death with the Maryland Hygiene. Hybier than "naturel", or Items 23a or 28a-1 ehow ent, Ite Mudical Exama act ment to inclified at	Funeral Director	4311 Marble Hall Road	12. Was Dec Armed Fo	rces?	n U.S.	13. Was Dece	dent of Hi	21218 spanic Orig n, Mexican,		cify Yes or No- Rican, etc.)			rican Indian,	
72 hours afte	۵	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Gi Year or D	Ve	16a D	1 🗆 Yes	1 ☐ Yes 2 No Specify:					·	Black	
d within 72 giene. er than "na	Completed	(Specify only highest	grade completed) College (1-4or 5+)	- Ida. (C	give kind of wife. DO NOT i	ork done d ise retired,	wring most Worket		ng			Maryland	
should be filed and Mental Hyg imarked other ametic event,	To Be C	17. Father's Name (First, Middle, Leo				18. Mother	r's Name	(First, Middle, A	^{faiden Sumam} y Graham					
i, Mary and 2 shou balth and M n 27 is mar ier traumat		19a. Informant's Name/Relationsh Imani Shabazz Daugi								Route Number,			Zip Code)	
DESILITION OF WAIT YIGHTO ATATION OF DOUGH PARTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY IS MARKED OF THE MADICAL EXAMENT OF HEMS 23 R. O. 28a-1 6 how any injury or other traumatic event, the Madical Exament in the malfies any injury or other traumatic event, the Madical Exament in the malfies and once.	İ	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from		cemetery,	isposition (Na crematory or etro Crem	other place			ate 01/26/07	20c. Location - Caton		Town, State Maryland	
Dalli permit. Departm Imports any inju		21. Signature of Funeral Service T	999 990	nuto	W	22. Name a	nd Addres step Br 300 Eur	s of Facility others F taw Place	unera ce Bal	al Service, P timore, Md	. A. 21217			
© Pnysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracerebral Hemorrhage Due to (or as a consequence of):												en ath
/Medical Examiner	_		_{b.} Coca	ine U									2 weeks	S
certificate be executed ding physician and use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Aut) that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):												
death certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)						23d. Date of delivery Month Day Year				
	þ	Part II. Other significent condition Hypertension		eath but not	resulting in the	ne underlying	cause give	en in Part I.				ribute to	the cause of dear	
e law	Completed	Diabetes Mel	litus							24a. Was an autops perform	ned?	Were audorior to dieath?	itopsy findings ava completion of caus	ailable se of
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DIVISION al or Attending s after death. I Director: After id in by the fune	ertific	3 Suicide 6 Could n 4 Homicide determi	ned 289. Place	e of Injury - A ling, etc. (Sp		street, facto	ry, office		2	28f. Location (St. City or Town		er or Ru	ıral Route Numbe	r,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical C	29a. Certifier 1 Certifying (Check only one)	g Physician: To the exeminer: On the band man	e best of my easis of exam ner stated.	knowledge, on ination and/o	death occurre or investigatio	at the tim	ne, date and pinion, deat	d place, a	and due to the ca ed at the time, da	use(s) and ma ate and place,	inner as and due	stated. to the cause(s)	
Totl withi Totl comp	×	29b. Signature and title of certifier			N	25	R. License	number	00		Janua	Monti	1. Day, Year)	07
8		30. Name and address of person v	who completed cau	se of death ((Item 23a) (Ty	ype, Print)		Sin	a.	Hospit	a(-	Bal	ti mos	و
Sta Registra		31. Date filed (Month, Day, Year)	2007	Registrar's Si	ignature	parts								

		4	For State Registrar	State of I	Marylar				lealth a Death	and M		giene Reg. No.	07	02431
	Physici	an	Decedent's Name (First, Middle, L. Donald	S.	S	chappe	וו				2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, g			Спаррс		Town, or	Location of	of Death	Januar	y 28, 20 4c. Count		8:20 P M
	Examin	er	Eastpoint Nursin		,			Dunda					timor	e.
	Funeral				Age (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	th v. Year)	9. Birth	place (State or Foreign
	Director			180 M 2 L F		68 Yrs.		34,4			January	10,1939		sylvania
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary in the	ţ	Maryland Baltim	ore		Dun	dalk							1 ☐ Yes 2 X No
	h the	lec	10e. Street and Number					Code				10g. Citizen of	What Cou	ntry?
	23a c	alD	7709 Nordbruch A	venue				21	222			US	Α	
920	be filed within 72 hours after death with the Maryland at Hygiene. Id Hygiene. Id other than "netural", or iteme 23a or 28a-f show orent. Ite Madical Examination with the motified at the continued at the cont	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑No	1	Was Dece f Yes, spe 1 Yes		ispanic Ori In, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		ce - Ameri ick, White, fy: Whi	
Baltimore, Maryland 21215-0036	within 72 h	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4)	or 5+)		dent's Usu kind of wo DO NOT u	ork done d se retired	ation during mos l)	t of worki	ing	16b. Kind of E		·
2 0	filed with Hygiene. other ther		12 years 17. Father's Name (First, Middle, La.	st)		Auc	.00.	rver	18. Mothe	r's Name	(First, Middle,			
<u>8</u>	should be filed ind Mental Hygi marked other umatic event.	To Be	Ellwood Schappel	1					Velr	na K]	leckner			
ary	2 shou and N is mar		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	(Street	and Numbe	r or Rura	al Route Numbe	er, City or Town	, State, Zip	Code)
Σ.	s 1 and 2 should of Health and Mer item 27 is marke other treumatic		Dana Schappell	S	on	-					Dundalk			1222
more	Page nent c ant: if ant: ury or		20a. Method of Disposition 1X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		1 ,	Place of Dispo cometery, crer ly Hill	natoniari	ather plan		Febr	uary 007	20c. Location Middle	•	
Balt	Departic Departic Importic eny inju		21. Signature of Funeral Service Lic	ensee Onn	ell	4 3	onne 110	d Addres Solle	unera ers Po	il Ho	ome Of I	Dundalk Dundalk	P.A.	21222
Ar a	Physician /Medical		23a. Part1. Enter the disease of co shock, or heart failure. In Immediate Cause (Final disease or condition resulting in death)	a. Pre	ed the deat line. Omeni as a conseq	a	er the mod	de of dyin	g, such as	cardiac d	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
34	certificate be executed XX iding physician and ise as the burial-transit	I Examiner	Sequentially list conditions, if any leading to it, mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequal									
68760	physicate I	dlcal		d				-					-	
B	deeth d for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta tat time of c	ıldeath 3□]Ectopic p] Other (s)						ate of delive	ery Day Year
rds, P	es tha	by	Part II. Other significant conditions	contributing to deatl	n but not res	ulting in the u	nderlying (ause give	en in Part I			obacco use con	tribute to t	he cause of death?
l Hec	The law ate has b page 2 st	Completed										rmed?	prior to co death?	opsy findings available impletion of cause of
VIE	iiclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			Check only o			
on of	ding Phys h, After this funeral dir	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of li		28b. Time of Injury		28c. Injun Work			me 5 Residence 128d. Describe to			(y)
Division	Hospitel or Attending Physicien: 44 hours alter death: Funeral Director: After this certific tely filled in by the funeral director,	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At h etc. (Specif	ome, farm, str y)					28f. Location (S City or Tox		ber or Rura	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier 1 Certifying 1 Certifying 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examina	owledge, death	occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the e	cause(s) and m date and place,	anner as s and due to	tated. o the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	~_ 1/	10			c. License				29d. Date signe		
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	3			HARMA	789		Print)	ovel	Ld.	HIL	1 , 60	en Bur	ve, 1	9,2007
P. C. S.	Sta Registr		JAN 3 0 200	407	strar's Signa	Loon								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAN 26.2007 3:12PMM MARIA GOMEZ SOTO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Country) |

A PRIL 12, 1914 | MEXICO FORT WASHINGTON HOSPITAL PRINCE GEORGE"S 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 1□ M 2□ F **Funeral** Director 314 26 8676 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Be Completed by Funeral Director PRINCE GEORGE'S 1 ☐ Yes ZYNo MARYLAND FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8088 DELLA LANE 20744 UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if them 27 is marked other thermany injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3

Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 ASSEMBLER STEEL FACTORY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sabino Gomez ABUNDIA BECERRA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JESUS SOTO, JR. (son) 8808 DELLA LANE, FORT WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) JAN31, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 21. Signature of Funer 22. Name and Address of FacilitYEE FUNERAL HOME, INC 6633 OLD ALEXANDRIA FERRY RD, CLINTON, MD 20735 P rt1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Isease or condition resulting in death) agestion Hourt Failure. **Physician** /Medical there sclentic Heart Disease Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ilux to The me. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed dystune 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☐ №6 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) after death.

I Director: After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1142955 30. Name and address of person who completed cause of death (item 23a) (Type, Print) POTTER, JR. M.D., 1328 SOUTHERN AVE, S.E. WASHINGTON, DC 20037

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 0

2007

Division or Vital Records, P.O. Box 68760,

32. Registrar's Signature,

Legion

State of Maryland / Department of Health and Mental Hygie 1 - State Registrar State of Maryland / Department of Health and Mental Hygie Certificate of Death	2111/12533
Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
Physician William Graham Stephens JAN of	33 2007 10:10 M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) It Under 1 Year If Under 24 Hrs. 8. Date of Birth	MARTORS
Funeral Director 228-28-4287 Social Security Number 2.38 Social Security Number 3. Social S	
Usual Residence of Decedent	10d. Inside City Limits
Maryland Harford Bel Air	1 ☐Yes 2 ☐ No
Maryland Hartord Bel Alf 10e. Street and Number 10f. Zip Code 10g.	. Citizen of What Country?
400 East Crocker St. 21014	USA
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Marital Status 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
3 Widowed 4 Divorced Year or Dates:	Specify: White
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Main life.) 18. Mother's Name (First, Middle, Main life.)	b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) Sales	etail Beauty Supplies
D S T T T T T T T T T T T T T T T T T T	iden Sumame)
John A. Stephens Lura Senate Cent	re
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Co. 400 East Crocker St., Bel Air,	
TO THE THE THE THE THE THE THE THE THE THE	c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State Highview Mem. Gardens 01/26/2007 Fa	allston, Maryland
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Fune	eral Home, P.A.
1317 Cokesbury Road, Abingdo	
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Interval Between Onset and Death
Physician /Medical Immediate Cause (Final disease or condition resulting in death) A Due to (or as a consequence of):	4/3
Examiner	CINT
Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events)	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	eco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 23e. Did tobac 1 Yes 24a. Was an autopsy performed	2 No 3€ Probably 4 Unknown
24a. Was an autopsy performance of the state	24b. Were autopsy findings available prior to completion of cause of death?
Was case referred to medical examiner? 25. Was case referred to medical examiner? Hospital: 26. Place of Death (Check only one)	
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27. Manuar of Death 116 Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury Work? 28d. Describe how injury	
Solution Significant Significa	
28d. Describe how in the control of	et and Number or Rural Route Number, State)
	se(s) and manner as stated.
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the control of the cont	. Date signed (Month, Day, Year)
D 2 6 2 4 2	124 67
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIPI KHOSHA 20CHAYSST #102, BELAIR, MD 2 State Registrar 31. Date filed (Month, Day, Year) AN 3 0 2007 32. Registrar's Signature	-1014
I KALINET I I I I I I I I I I I I I I I I I I I	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g863 1-30-07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Louis Snowden Jr. Month Day Physician 14211 M DNOWDEN JANUARY 22, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS BALTIMORE CITY If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 11 05 Year) 34 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2 ☐ F 72 212-30-2397 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Y∏Yes 2∏No Funeral Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2104 North Pulaski Street 21217 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed X Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth grade Laborer Various Jobs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ۵ Louis Snowden Erma Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 North Aisquith Street, Balto, Md 21202 Alexis Alsup-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or King Memorial Park 1/29/07 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. P.111. Enter the disease, or complication. hat cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm viate Cause (Final dis as se or condition resulting in death) **Physician** BLADDER CANCER METASTATIC 1 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performe Yes 2 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed has certificate Physician: this Hospital or Attending

A pue

physician

attending

4

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier Naik, MD 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

RES-000

BALTIMORE,

22,2007 JANUARY

MD 21205

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKHI NAIK 31. Date filed (Month, Day, Year)

> JAN30 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sandra 1200/Yach 2007 an /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bon Secours N/A Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 216-52-3788 4, 1949 Maryland Director Apr. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nortified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1X Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1821 McHenry Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 21☑ No White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Healthcare Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Augusta Wilt George Edward Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1821 McHenry Street, Baltimore, MD 21223 of Disposition (Name of Date 20c. Location - City or Town, State David R. Shears, Sr. Husband 20b. Place of Disposition (Name o 20a. Method of Disposition Cemetery MD Vet. X Burial 2 □Cremation 3 □Removal from State 1-29-2007 Owings Mills, MD 4 Donation 5 ☐ Other (Specify) Chrrison Forest Ambrose Funeral Home, Inc. 21. Signature of Funeral Service License 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Anowe Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a porsequence of certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nerformed' certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 HO 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Zecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) Sputh, MS DOOS 2950 29d. Date signed (Month, Day, Year)

See of death (Item 23a) (Type, Print)

See of Battimore, MD 3/20/

State Registrar

07-00576 Shirley Maria Spencer

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of He	alth and Mental Hygiene

		1- For State Registrar			Cer	tificate of	Death		7.3	Re	g. No. 201	07.021.3
Physicia dical Exami	an/	1. Decedent's Name (Fin Shirley Man								Date of Death Month January 21	Day Year	3. Time of Death O935 hrs
		4a. Facility Name (if not	t institution, give		r)		b. City, Town,			andary 2	4c. County of De	
Funeral		5. Social Security Numb		(T. A	ige (In yrs. la	ast birthday)	Halethorpe		er 24Hrs. 8	B. Date of Birtl	Baltimore C	
Director		212-26-7974	4 1	м 2 ^X Г	78	Yrs.	Months Da	_	1		For	reign Country) MD
land f show any ance.	or	MD Ba	.county altimore	9		Town or Locati downe						10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e Street and Number 821 Fifth A					10f. Zip Code 21227				s. S.A.	ountry?
er death with	Funeral	11. Marital Status 1 Never Married 3 X Widowed		12. Was Decede Armed Force 1 Yes If Yes, Give Year			s Decedent of Fes, specify Cub	an, Mexican	, Puerto Ric		White, etc	
2 hours afte "natural" I Examine:	ted by	15. Decedent's Educat	ition (Specify on	or Dates:			t's Usual Occup ost of working li	ation (Give	kind of work		Specify: Wh	
5-0036 iled within 77 Hygiene I other than the Medical	Completed	12 17 Father's Name (Firs	it, Middle, Last)			Seamst	ress	18 Mother	's Name (Fi	rst, Middle, M	Textiles	
1215 d be file ental Hy arked o	Be	Robert Whee						1		neehag		
MD 2 d 2 should lth and M n 27 is m		19a. Informant's Name/F Robert S. S	Spencer			648 Au	ıtumn Sk	ty Cou	rt Sy	kesvil	ber, City or Town, St. 1 e MD 217	84
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposit 1 X Burial 2 0 4 Donation 5	Oremation 3 Other Specify		State Eve	rematory or other ergreen	ition (Name of c ner place) Memori Sardens	al	1-27-			g, Maryland
Balt permit Departs Import injury		21. Signature of Funera	12-X	molle		13	ame and Addre	nur Sj	oring	Rd. Ar	neral Home butus MD	inc. 21227
Physician /Medical	2 1/3	23a. Part I. Enter the dis failure. List only	ne cause on ea	ch line.					cardiac or re	spiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Fina or condition resulting in		Hypertensive and output to (or as a cor			Ovasculai D	risease				
ne ^p	aminer	Sequentially list condition in the cause. Enter Underlying	diete	Tue to (or as a cor	ise # ience of	f):						10
scuted and transit	ŭ	(Disease or injury that in events resulting in deat	initiated ^{C.} -	Due to (or as a cor	sequence of	f)·						
760, icate be execut physician and the burial - trait	/Medical	UNPENDED		AMENDED								
	sician/Me	IF FEMALE: 23b. Was decedent preg past 12 months?		23c. If yes, outon		2 Fe	tal death 3	B Ectopi	c pregnancy	/	23d Date of delive	very Day Year
that the death certife need by the attending detached for use as	Phy	Part II. Other significan		9 Unknown contributing to de	ath but not re	esulting in the L	inderlying cause	e given in Pa	art I	23e. Did to	bacco use contribute	to the cause of death?
S, P.O. puires that the signed by an signed by	ed by											Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ompleted									24a. Was a autops perform	sy prior t med? death	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred t examiner?	<u> </u>	ospital:					(Check only			
n of Vit ding Physic After this funeral dire	٢	1 ✓ Yes 2 27 Manner of Death	No	28a. Date of I	tient 2	ER/Outpatient 28b. Time of I		Other ₄	Nursing F		Residence 6 🗸 Ot	ther: Scene
ion (trending death	ation	1 Natural 5	Pending Investigation	(Month, Day	y,Year)		1	Yes 2	No			
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Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	TOTICON OTHE			kamination a						e(s) and manner as s and place, and due to	
F 3 F 3	Me	29b. Signature and title						nse number			29d. Date signed (
١		30 Name and address		completed cause of	f death (Item	23a)	1 0.0	Z. IVI. I			January 22, 20	JO.
le	<u>_</u> ,	Ling Li, MD	Assistant M	edical Examir	er 111	Penn Stree	et, Baltimore	e, MD 212	201		7	
S Regis	tate trar	31 Date filed (Month)	13°0 201	7 3 Regis	rar's Signat	re Gos	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

James	Barton	Samons,	Sr.
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anies Darton San	1- For State Registrar Certificate of Death Reg. No. 2007	43
Physician Medical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year January 13, 2007 3 Time of Death Month Day January 13, 2007	
· · · ·	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 111 Ilene Road 4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 309-72-5949 6. Sex 1. Age (In yrs. last birthday) 46 Yrs. Months Days Hours Min. Jun. 19, 1960 Foreign Country) MD)r
15-0036 filed within 72 hours after death with the Maryland Hyggene 2d other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lar White, etc. 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes, specify: 17. Yes 2 No specify: 18. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. White, etc. 19. Specify: 10. White	X No
21215-0036 Muld be filed within 7 Mental Hygiene marked other than e event, the Medica	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Turner Samons Betty Gibson	
MD 21215- and 2 should be filed and 2 should be filed and Mental Hyg an 27 is marked oth aumatic event, the		==(1
Baltimore, MD 21 permit. Pages I and 2 should! Department of Health and Mer Important: If item 27 is man injury or other traumatic ev	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21 Silvature of Funeral Service Licensee 22b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory 22 Name and Address of Facility Ambrose Funeral Home, Inc.	
m ឱ្ង≣≣ (Physician	2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate	Interval
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Creates or Figury 8 to ticilitated.	nset and
760, icate be executed physician and the burial - transit	d. VINPENDED AMSINGER TI, 27, permE, g865, 3/2/07 Tt	
P.O. Box 68760, s that the death certificate be greed by the attending physic detached for use as the bure by the busician/Mood	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	'ear
Records, P.O. The law requires that the ficate has been signed by the page 2 should be detached.		nknown
tal Recor cian: The law r certificate has b ector, page 2 sh	autopsy prior to completion of ca death? 1 ✓ Yes 2 No 1 ✓ Yes 2	
n of Vil ding Physic After this funeral dir	25. Was case referred to medical examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending 28. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	
Division o Hospital or Attending 4 hours after death Funeral Director: Afterly filled in by the fune	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number of Town, State)	ber, City
To the Hos within 24 h To the Fun completely	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 23, 2007	
	30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat	31. Date filed (Month, Day, Year) 32 Registrar's Signature	
Registra DHMH 17 Rev 1/200	JAN 3 0 2007 ORIGINAL	

07-00582

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rittany Shore	1- For State Registrar	Maryland / Department of Certificate of		Hygiene Reg.	No. 200	7 0243
Physician Medical Examina		2070		2. Date of Death Month	lay Year	3 Time of Death 1134 hrs
and the same of th	4a. Facility Name (if not institution, give street		b. City, Town, or Location of Dea	January 21,	4c. County of Death	
	University Hospital		Baltimore		N/A	
Funeral Director	5. Social Security Number 6. Sex 213-33-4768	7. Age (In yrs. last birthday) 2 X F 15 Yrs.	If Under 1 Year If Under 24H Months Days Hours Mi		MM/DD/YYYY) 9. Birti Foreign Cou	
any	10a. State 10b. County	10c. City, Town or Location	n			10d Inside City Limits
Maryland 28a-f show 1 at once	MD N/A		Baltimore			1 X Yes 2 No
tth the Maryland 23a or 28a-f sho notified at once	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
with the			21223 Decedent of Hispanic Origin? (Specify Yes or No-	United 9	
death v	1 21 Never Married 2 Married 1		s, specify Cuban, Mexican, Puer		White, etc.	
s after c	3 Widowed 4 Divorced in res	, Give Year 1	Yes 2 X No specify:			√hite
2 hour	15. Decedent's Education (Specify only hig Elementary/Secondary (0-12)		s Usual Occupation (Give kind or st of working life. DO NOT use re		6b. Kind of Business/Ir	ndustry
5-0036 cd within 72 hour lygiene other than "natu he Medical Exar	8		N/A		N/A	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than e event, the Medica				ne (First, Middle, Mai	,	
	19a. Informant's Name/Relationship (Type, F		Address (Street and Number or	cesa Thomp		Zip Code)
MD nd 2 sho alth and m 27 is	Robert Shore - Fathe		ricker Street,	Baltimore	, MD 21227	7
Baltimore, permit Pages I ar Department of Hee Important: If ite		emoval from State crematory or other			20c. Location - City or	
Itim	4 Romation 5 Other Specify:	Qedar Hill	Cemetery 1-	-26-2007	Brooklyn,	MD
Den Den Ba	Januare Co	132	8 Sulphur Sprir	ng Rd., Ar	butus, MD	21227
Physician // // // // // // // // // // // // //	23a Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Do not enter the e.	e mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
xaminer		emporal lobe brain absce	ess			Death
and the second	Sequentially list conditions.	r infection				
	if any, leading to immediate Cause Enter Underlying Cause (Disease or injury that initiated	o (or as a consequence of):				
ted Insit	events resulting in death) Last	o (or as a consequence of):				
760, cate be executed physician and he burial - transit	d. AM	#23a-b,27,perME,				
760, icate be physici the buri		c. If yes, outcome of pregnancy		-	23d Date of delivery	
Box 687 e death certific the attending ped for use as the	past 12 months?	Progrant at time of death	al death 3Ectopic pregi er (Specify)	nancy	Month D	ay Year
D.O. Box 687 that the death certific ned by the attending p detached for use as th		Unknown		OO Didah		
i, P.O.	े	ibuting to death but not resulting in the ur	iderlying cause given in Part I		cco use contribute to t	
ords, F w requires s been sig				24a. Was an		opsy findings available
Records, The law require are has been signage 2 should b				autopsy performe	ed? death?	ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law require at a first cleath at Director. After this certificate has been siled in by the funeral director, page 2 should be difficulties. To De Complete	25. Was case referred to medical		26 Place of Death (Chec			, 2 110
Physic er this	1 Ves 2 No	Impatient 2 Proutpatient		ing Home 5 Re	sidence 6 Other	
ion of tending Ph cath for: After the funeral	1 X Natural 5 Pending	8a. Date of Injury (Month, Day, Year) 28b. Time of In	1 Yes 2 No	20d. Describe 110v	v Injury occurred	
Division of ital or Attending Lrs after death ral Director: After lled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home, farm, street	, factory, office building, etc.		eet and Number or Run	al Route Number, City
Division ospital or Attend hours after death meral Director: y filled in by the	200 Continue	(Specify)		or Town, Stat		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - trans.	(Check only one) 2 Certifying Physician: T Medical Examiner: On the	o the best of my knowledge, death occurr ne basis of examination and/or investigation				
F Viring 5	29b. Signature and title of certifier	manner stated.	29c. License number	2	9d. Date signed (Mon	th, Day, Year)
	Carol Ha	llar	O.C.M.E.	,	January 22, 2007	
	30. Name and address of person who compl Carol Allan, MD Assistant M	, ,	treet, Baltimore, MD 212	01		
Stat		32. Segistrar's Signature	and a substitution of the			
Registra	JAN 3 0 2007	Steem & Age	w			
DHMH 17 Rev 1/200	1	ORIGINAL				

	1	State	laryland / D		t of H	ealth and		ygiene	007	02439
Physiciar /Medica Examine	n il -	1. Decedent's Name (First, Middle, Last) An Si'nglet Aa. Facility Name (If not institution, give street and number Howard Country Gen	91)	· An City	Town, or	Location of De		uan 2	ounty of Dea	
Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ge (In yrs. last birt		1 Year Days	If Under 24 H Hours M	in. (Month,	Birth Day, Year) 12, 1918	C	thplace (State or Foreign ountry) So. Carolina
death with the Maryland me 23a or 28e-f ehow rmust be notified at		Usual Residence of Decedent 10a. State 10b. County Maryland Howard	10c. City, Town	or Location	Co	olumbia				10d. Inside City Limits 1
with the	ਤ ∣	10e. Street and Number 5633 High Tor Hill		10f. Zij	Code	21045		10g. Citize	n of What C	ountry? S.A.
urs after	by Fur	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Deceder Armed Forces 13 Was Deceder Armed Forces 14 Was Deceder Armed Forces 15 Was Deceder Armed Forces 15 Was Deceder Armed Forces	[?]]No 1949	13. Was Dece If Yes, spe		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or ento Rican, etc.)		Race - Am Black, Whi	erican Indian, te, etc. Black
4 1 2 1 5 - U swithin 72 ho jiene. Tithen "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40		Decedent's Usu (Give kind of wo life. DO NOT u	rk done d se retired,	ution during most of v Personne			of Business Jnited St	Andustry tates Military
be file tal Hyg d othe	To Be C	17. Father's Name (First, Middle, Last) Felix Singleton				18. Mother's N	Name (First, Midd	dle, Maiden Su orence V		
Mary nd 2 sho aith and 27 is my r traum		19a. Informant's Name/Relationship (Type, Print) Samuetta Singleton		5633 Hi	h Tor	Hill Colum	Rural Route Nur ibia, Marylai		own, State,	Zip Code)
Pages 1 Then of He tant: If then the tant of the tant		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Denation 5 □ Other (Specify)	e	Disposition (Na y, crematory or uilford Chu	ch Ce	metery	Date 02/03/0			r Town, State a, Maryland
permit Depermit Impor		21. Signature of Funeral Service Lie See	len X	22. Name a	step B	rothers Fu	uneral Service Baltimore,	ce, P. A. Md 21217	7	Approximate
e bury	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	is a consequence of the conseque	go-car odstern ods cal	l p	neu	nom	el .		Interval Between Onset and Death
ut the death certificate by the attending physitached for use as the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of the transfer of trans	by Physician/Medi		ne of pregnancy 2	3 DEctopic p				23	d. Date of de Month	elivery Day Year
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	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa	tient 2 ER/Ou	tpatient 3 D	Othe	ne.	Death <i>(Check on</i> ig Home 5□R		□Other (Sp	ecify)
ISION Itending deeth. Stor: After	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of In (Month, it are a limited) 5 Could not be determined 28e. Place of building.		М		yat c? Yes 2 □ No	28f. Locatio	n (Street and Town, State)		Route Number,
_ a s = 0	edicai C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis and manner	of examination an	dealth occurred d/or investigatio	l at the tim n, in my of	ne date and pl pinion, death o	ace and due to to occurred at the tin	he cause(s) a ne, date and p	nd manner t lace, and du	ue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier		29	C. Licenso	o Romber	0	Z9d. Date	signed (Mor	nth, Day, Year)
14		30. Name and address of person who completed cause of SUZCON And 5005	death (Item 23a)	(Type Brint)	Las	ne C	Coulisa	ille.	ND	21029.
Stat Registra		31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	booth						

			For State Registrar	State of Ma	aryiand	•	rtment of F tificate of		vientai Hy	/gien Reg. N	2007	0244	0
S	Physici	an	1. Decedent's Name (First, Middle, Las Fredr	ic Thomas	Suss.	Sr.			2. Date of D Month		ay Year	3. Time of Death	M
	/Medic	cal	4a. Facility Name (If not institution, give		bass,	51.	4b. City, Town, or Location of Death				6, 2007 c. County of Death	3:55 P	,VI
	Examin	lei	10505 Unity Lane				_	otomac			Montgome	erv	
	Funeral Director		001 07 6010						Q Right	place (State or Forei	gn		
ING 21213UU36 be filed within 72 hours after death with the Maryland tital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Me Arai Examiner must be notified at	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer 10c. Street and Number 10505 Unity Lane 11. Maritai Status	tate 10b. County 10c. City, Town Yland Montgomery Potomac treet and Number 505 Unity Lane arital Status 12. Was Decedent Ever in U.S. Armed Forces?			10f. Zip Code 20854	l Hispanic Origin? (S an, Mexican, Puert	pecify Yes or N	Un:	Citizen of What Cou	es can Indian,	
	ours after rai", or ite Examine	by	1 ☐ Never Married 2 ☐ Married 3本 Widowed 4 ☐ Divorced	1 ⊠ Yes 2 ☐ N if Yes, Give Year or Dates: 2			l □ Yes 21⊠ No		o riican, etc.)		Black, White, Specify: Wh	eite nite	
	thin 72 ho e. an "natu i Me ical	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	_ College (1-4or 5		(Give life, L	DO NOT use retire	during most of wor	rking	16b.	Kind of Business/In	dustry	
nd 21	m = 0 %	å	17. Father's Name (First, Middle, Last)	5 +		Judg	ge	18. Mother's Nan			Law en Surname)		
Maryland	hould be f id Mental I marked of matic eve	ပ္	George Suss 19a. Informant's Name/Relationship (7)	Type. Print)		19h. Mailin	a Address (Street	Rose C		her City	or Town, State, Zi	n Code)	
-	and 2 sealth ar		Christopher P. Sus		8	800 Ba	ay Front	Avenue,			h, Maryla	,	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	<i>'</i>)	St.	e of Dispo etery, cren Peter	sition (Name of natory or other place s s Cemet	Janu ery 31,	ary 2007		Location - City or To enstown,		
Balt	permit. Departi Importi any Inj		21. Signature of Funeral Service Licen	see Eli M0009	92	R C	Name and Address	ess of Facility Ro Inc. 30 Marylan	bert A. 0 Vesto	Pur Mont	mphrey Fu	neral Home venue	е
	Physician	0 1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each lin Alzheir				ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death 13 years	
	/Medical Examiner		resulting in death)	Due to (or as									
1	acuted .nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as									
68/60,	ificate be executed g physician and as the burial-transit	edical Ex	resulting in death) East	Due to (or as	a consequen	ice of):							
O. Box 6	death certif e attending d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3□	Ectopic pregnance Other (specify)	у			23d. Date of deliv Month	ery Day Year	
ras, r	requires that the een signed by th nould be detache	ρ	Part il. Other significant conditions of	ontributing to death b	ut not resultin	ng in the ur	nderlying cause giv	ven in Part I.			o use contribute to t 2X No 3 □ Pro	he cause of death? bably 4 □Unknov	vn
I Records	The la	Completed							24a. Was auto pert 1□ Yes	opsy ormed?	prior to co death?	opsy findings availab impletion of cause o	le f
VItal	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea	ath (Check only	one)			
10 UC	hys ldii	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Day	nt 2 □ ER ry 28 ⁄ Yea <i>r</i>)	Outpatien Bb. Time of injury	28c. inju	4 🗆 Nursing 🗆	lome 5 Res 28d. Describe		6 ☐Other (Speci jury occurred	fy)	
UIVISION	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After to completely filled in by the funera	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home c. (Specify)	, farm, stre	eet, factory, office	2 2 110	28f. Location City or To	(Street own, Sta	and Number or Run afe)	al Route Number,	
	e Hospita 24 hours e Funeral	Medical C	29a. Certifier 1	ysician: To the best on hiner: On the basis of and manner sta	examination	edge, death n and/or in	occurred at the tivestigation, in my	me, date and place opinion, death occu	and due to the urred at the time	e cause e, date a	(s) and manner as s and place, and due t	stated. to the cause(s)	
Y =	To th within	Me	29b. Signature and title of certifier	V C			29c. Licens D0060				Date signed (Month,		
'	15		30. Name and address of person who of Brent K. Cole, M.					30. Chev					_
	Sta Registr		31. Date filed (Month, Day, Year)	OO Desister	ar's Signature				y we de not had the	, ~~~			
DH	MH 17 Rev 1/2	001	JAN 3 0 2	1007 1000	Carl Su	1	14.111						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 Helen K. Sutherland January 25, 2:35 A^{M} 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 12, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2XF Hours Vrs 87 520-07-0211 Colorado Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 X No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3552 Chiswick Court 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Administrative Research National Institutes Elementary/Secondary (0-12) College (1-4or 5+) of Health 4 Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Charles Keiser Ora D. Cary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Sutherland/Son 4913 Redford Road, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a Method of Disposition 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Torium, Inc. 2007 Bethesda, Maryland
Robert A. Pumphrey Funeral Home/Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature of Funeral Service Licenses

permit. Pages 1
Department of H
Important: If ite
any Injury or ot **Physician** /Medical Examiner

physician

attending

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Director:

n 24 hours after d e Funeral Direct

within 24

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O.

Box 68760.

Physician

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Certification:

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death

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene. Is marked other than

item 27 l

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

Metastatic Pancreatic Cancer

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

9 Unknown

4☐Pregnant at time of death 9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 ☐ Inpatient

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1☐ Yes 2 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 XNatural 2 Accident

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

29c. License number H0058032 rithia M Milliams Do

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road, Rockville, Maryland 20855 Cynthia M. Williams, D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar



DHMH 17 Rev 1/2001

2X No 3 Probably 4 Unknown

Year

Hospice

4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene UU/ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 20, 2007 10:05 PM Mary Steckley /Medical 4c. County of Death 4b. City. Town, or Locetion of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. June 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 81 Yrs. **Director** 095-20-1290 Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Montgomery Village MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 19301 Watkins Mill Road 20886 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 \ Widowed 4 □ Divorced \$ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic svent 9DRB. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suburban Hospital 8600 Old Georgetown Road Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 NOther (Specify) in state 21. Signature Ronald Signature Director State and Address of Facility and 655 W. Baltimore Street 21201 Baltimore, MD arm Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No After this certificate has 1 Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 00057124 como 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Dr Rockville, MD Medical Troung MD 9715 Bao 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 3 0

07-00227	
Alan Simanski	

lan Simanski		State of Maryland / Department of 1- For State Certificate of Registrar			No. 2007 02443			
Physicia Medical Exami	ın/	Decedent's Name (First, Middle,Last)		Date of Death Month	3. Time of Death			
TOTAL EXAMINATION	IIGI	Alan Simanski 4a Facility Name (if not institution, give street and number) 4	b. City, Town, or Location of Death	January 8,	4c. County of Death			
2		Old Mall-Beaglin Drive entrance	Salisbury		Wicomico			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 153-46-4641 1X M 2 F 52 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min.	_	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)New Jerse			
		153-46-4641 1X M 2 F 52 Yrs. Usual Residence of Decedent		Apr 0,	1754 Country/New Series			
w any		10a State unk 10b County unk 10c. City, Town or Location	on		unk 10d Inside City Limits unk Yes 2 No			
daryland 28a-f show 1 at once.	ģ	10e. Street and Number unk	10f. Zip Code	unk 10g	g. Citizen of What Country?			
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036 thin 72 l ne r than "1	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	_	,	pest control			
5-00 led with tygien other	S	17. Father's Name (First, Middle, Last)	control operator					
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be	Charles Simanski 19a Informant's Name/Relationship (Type, Print) (19b. Mailing	Marilyn Address (Street and Number or F		on City of Town Chairs (To Code)			
MD 2 nd 2 shou lith and M m 27 is n	ř		Cambridge Avenue					
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med			tion (Name of cemetery,		20c. Location - City or Town, State			
Baltimore, permit Pages I an Department of Hea Important: If iter		4 Donation 5 X Other Specify: in state						
Bal permi Depar Impo			ate Anatomy Boar Ltimore, MD 212	d 655 W.	Baltimore Street			
Physician		3a. Pall I. Enter the disease, or complications in caused the death. Do not enter the failure List only one cause on each line.			st, shock, or heart Approximate Interval Between Onset and			
/Medical Examiner		Immediate Diuse (Final disease or condition resulting in death) Hypothermia with complication for condition resulting in death) Due to (or as a consequence of):	ations		Death			
		Sequentially list conditions, b						
	niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.						
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):						
e execution and and and and and	Medical	X UNPENDED X AMENDED #4c,23a,27,28a-f perME, 9865, 3/7/07 TT						
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	/Mec	23c, if yes, outcome of pregnancy			23d Date of delivery			
Box 687: death certific	ician	past 12 months? 4 Pregnant at time of death 5 Ott	tal death 3 Ectopic pregna ner (Specify)	ancy	Month Day Year			
he de hed	Physician/	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e Did toh	acco use contribute to the cause of death?			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	by		madifying datase girsinin and		2 No 3 Probably 4 V Unknown			
cords, law requii has been a	Completed			24a. Was a				
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ital Rec iician: The s certificate irector, page	å	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient	26 Place of Death (Check 3 DOA Other Wursin		Residence 6 🗸 Other Scene			
of Vir Ing Physic After this funeral dire	.t	1 V Yes 2 No Impatent 2 ENOutpatent 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year)			ow injury occurred			
sion ttendir death ctor: A y the fu	atio	Pending Investigation Fnd 1/8/2007 Fnd 12:3		-	exposed to cold			
Division pital or Atten ours after death eral Director	Certification:	3 Suicide 6 Could not be determined (Specify) Woods	et, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rural Route Number City ate) Ols Mall - Beaglin Drive			
Division To the Hospital or Attention Within 24 hours after death To the Funeral Director: completely filled in by the	1	29a Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occur	due to the cause					
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigate and manner stated.		at the time, date a				
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Month, Day, Year) January 9, 2007			
		30. Name and address of person who completed cause of death (Item 23a)	1.		•			
			treet, Baltimore, MD 2120	1				
S Regis	tate		arte					

ONK ONK		Registrar		epartment o Certificate o	of Health a of Death	and Menta	l Hygiene	-	,
Physic Medical Exan	ian ine	1. Decedent's Name (First, Middle, Last CHRISTINE STIGG(7				2. Date of D Month	Day Year	3. Time of Death
		4a. Facility Name (if not institution, given 1770 Tucker Road	e street and number)		4b. City, Town, FT. Wash	or Location of D	January eath	25, 2007 4c. County of	
Funera		Social Security Number 6. Security Number	7. Age (In y	rrs. last birthday)	If Under 1 Y		4Hrs. 8. Date of	Prince G	eorge's 9. Birthplace (State or
Director		263–96–3216 1 Usual Residence of Decedent	M 2 F	53 Yrs	Months D	ays Hours	Min.	2-1953	Foreign Country) FLORIDA
w any		10a. State 10b. County		City, Town or Locat	ion				10d Inside City Limits
daryland 28a-f show 1 at once.	ş	MD. PRINCE GE	ORGE'S	FT. WAS					1 X Yes 2 No
the Ma ta or 28	Director		CHTS DRIVE		10f. Zip Code			10g. Citizen of Wha	t Country?
death with the Maryland or items 23a or 28a-f sho	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in Armed Forces?		s Decedent of H	44-4662 Hispanic Origin?	(Specify Yes or N	USA 10- 14. Race -	American Indian, Black,
0036 within 72 hours after death with the Maryland jene rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once.	_	3 Widowed 4 Divorced	1 Yes 2 N	0 ""	Yes 2 X N	an, Mexican, Pue	erto Rican, etc.)	White,	etc.
hours a	ted by	15. Decedent's Education (Specify on	or Dates: ly highest grade completed) 16a. Deceden	t's Usual Occup	ation (Give kind	of work done	Specify B	BLACK ness/Industry
0036 within 72 hou iene rer than "nat	ompleted	Elementary/Secondary (0-12) -12-	College (1-4 or 5+)			e. DO NOT use	·		,
Hyg The	ပ	17. Father's Name (First, Middle, Last) THOMAS STIGGONS,		WAREF	IOUSE AL	MINISTR 18.Mother's Na	me (First, Middle,	AIR CO	NDITIONING
2121 hould be fi nd Mental is marked tric event,	To Be	19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Stro	INEZ	FASHAW		
MC nd 2 s alth ai		INEZ STIGGONS (MOZ		1 2020	HIGHLA	NI) PARK	BLVD. M	T DORA	State, Zip Code 32757
Baltimore, Dermit Pages Lar Department of Hee Important: Uite		1 X Burial 2 Cremation 3	Removal from State	 b. Place of Dispositions crematory or other 		emetery,	Date	20c. Location - Ci	ty or Town, State
Baltimo permit Pagi Department Important: injinry or ot		4 Donation 5 Other Specify: 21. Signalur Tuneral Service Lens	EI	OGEWOOD C	EMETERY	2-	3-2007	MT. DORA	FLORDIA
Physician		23a Pa 1 Enter the disease or compliance) HUBU	232	W. MIC	HAEL GL	RVIN ZAN ADDEN BL	DERS FUNE VD. APOPKA	RAL HOME
/Medical Examiner		23a Par I. Enter the disease, or complication of luring List only one cause on each lmme later Cause (Final disease a. M.	ations that caused the dea n line fultiple Injuries	ith. Do not enter the	e mode of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
LAdiminer			ue to (or as a consequence	of):					Death
275.00	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence	of):					
sit sq /	Examiner	(Disease or injury that initiated C.	ue to (or as a consequence	of):					2.3
execute an and al - tran		dd.	AMENDED						
760, icate be physici the buri	- 10	IF FEMALE:	23c. If yes, outcome of pre	gnancy				T224 B : : : : :	
Box 68' e death certification the attending ed for use as 1	sician	past 12 months?	Live birth Pregnant at time of controls	2 Fetal		Ectopic pregr	nancy	23d. Date of deli- Month	Day Year
	ΞL	1 Yes 2 No 9 V Unknown Part II. Other significant conditions	9 Unknown	Otile	r (Specify)				
Records, P.O. The law requires that the ficate has been signed by page 2 should be detach	اھ		ontributing to death but not	resulting in the und	derlying cause g	iven in Part I.			to the cause of death?
ords aw requir	Completed						24a. Was a	n 24b. Were	autopsy findings available
tal Reco		25. Was case referred to medical					autops perform 1 ✓ Yes 2	med? death	
of Vital ig Physician: fler this certi	0	Avaminos?	pital: 1 Inpatient 2	ER/Outpatient 3		of Death (Check			
on of Vinding Physics After this efuneral direction	- :uo	7. Manner of Death	28a. Date of Injury (Month, Day Year) Jan 25, 2007	28b. Time of Inju	ry 28c. Injury	at Work?	28d. Describe he	Residence 6 Otl	her: Scene
Division tal or Attendir rs after death. al Director: A led in by the fu	ບ	2 Accident Investigation	28e. Place of Injury - At h			es 2 V No	Driver auto a		
Div ospital or hours afte meral Div		4 Homicide determined	(Specify) Major Roa	d / Highway		7	1770 Tucker R	ate) oad, Ft. Washingto	Rural Route Number, City
To the Hospital within 24 hours a To the Funeral completely filled	5 1 6	9a. Certifier 1 Certifying Physician: ne) 2 Medical Examiner; or	To the best of my knowled the basis of examination a manner stated	ge, death occurred	at the time, date	e and place, and			
E 30	2	9b. Signature and title of certifier	d manner stated		29c. License			nd place, and due to 29d. Date signed (N	1
	21	Name and set			O.C.M	I.E.	}	January 26, 20	
6			pleted cause of death (Item / Chief Medical Exar		enn Street. I	Baltimore, M	D 21201		
Stat Registra		Date filed (Month, Day, Year)	32. gistrar's Signatu					· · · · · · · · · · · · · · · · · · ·	
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DHMH 17 Rev 1/2001

117 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh 9863 1-30-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** I homas heodore 27 anuin /Medical 2007 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frunder 1 Year If Under 24 Hrs
Months Days Houre Hopkins JOHNS HOSpital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 218-26-8345 N. CAROLINA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at BALTIMORE 1 Yes 2 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number E. FEDERAL STREET U.S.A. 2/2/3 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: BLACK 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) SPARROWS Foins Elementary/Secondary (0-12) STEEL WORKER 12 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ollie Belle THOMAS Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic evonce. DAVIS ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCIA THOMAS - SMITH 8107 Pleasant Plain Rd - Towson, MD. 21286 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 23 07 BALTIMOR, MD Woodlawn Gnetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VQUGHN Greene FUNCIAL SONICES, P.A. 21. Signature of Funeral Service Licensee M01363 4905 York ROAD. BALTIMORE, MD. 21212 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebral hemorrha /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- 000 Vasu M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 600 North Wolfe Street Baltimore Wesley Ms y Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

32. Registral's Signature State Registrar

DHMH 17 Rev 1/2001

2007

			For State	State of Maryla	nd / Dep		lealth and I	Mental Hygi	iene	02446
			Registrer 1. Decedent's Name (First, Middle, Las	(t)		Timeate of i	Dealit	2. Date of Death	ng. No.6	3. Time of Death
	Physicia			TRUMPF				Month	Day Year	alli
,	/Medic Examin		4a. Facility Name (If not institution, give			4b. City. Town, or	Location of Death	1 2	4c. County of Dea	
	Examili	er	Laurel Regional			Laure			Prince G	
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs	. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		176-34-0458	□M 2 □ /F 95	Yrs.	Months Days	Hours Min.	Mar. 12	1911 Pen	nsylvania
	2		Usual Residence of Decedent 10a, State 10b, County	100 0	ity, Town or L				-	Land Inside Charles
	ehov de	_				ocation			10d. Inside City Limits 1 ☐ Yes 2√0√No	
į	28a-f	Director	MD Prince 0	George's La	urel	101 7: 0-1-		1/	On Civina at Min at C	
3	J. O.	古		. a		10f. Zip Code	-		og. Citizen of What Co	oundy?
	10 23	Funeral	16205 Jerald Roa	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		necify Yes or No-	USA 14. Race - Amo	erican Indian.
	ite i	Ë	1 ☐ Never Married 2 ☐ Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	in, Mexican, Puert	o Rican, etc.)	Black, Whi	te, etc.
3	0.0	ò	3 XWidowed 4 ☐ Divorced	1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
	2 Should be littled within 72 hours after beant with the maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23a or 28a-f show sumatic event, its Medical Examinational be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occupa	ation	tina	16b. Kind of Business	/Industry
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4	ygien Ygien t,	ပ္ပ	12th	Ø	Н	omemaker			Own H	ome
3	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, N	faiden Sumame)	
	Men Merke	2	Leopold Geider				Theresa	Pumm		
3	is m is m		19a. Informant's Name/Relationship (7						City or Town, State,	Zip Code)
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5	nt of nt of nt of		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other place	1		,	
	njun		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			ndel Crem			Odenton, I Ave, Lau	
0	permit. Fages 1 and 2 should by Department of Health and Mente importent: If itsm 27 is marked any injury or other traumatic evonce.		aman	IAO - all		Donaldson				20707
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only							Approximate
			shock, or fleaft failure. List only immediate Cause (Final	one cause on each line.	4 .	•	•	. ,		Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	OC K					
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):					
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5	be executed ician and burial-transit	E	resulting in death) Last	Due to (or as a conse	quence of):					
-	hysic the bi	lcal		d						
5	ling p	Physician/Medi	IF FEMALE:	20- 14						
	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	tal déath 3 (Ectopic pregnancy			23d. Date of de Month	livery Day Year
;	the	yslo	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5t	Other (specify)				
	ed by detail		Part If. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
3	unes neign ld be	d by	Myelo	dyspia	cia			1 □ Ye	s 2□No 3□P	robably 4 Dunknown
3	shou	Completed		9.1				24a. Was an	24h Were a	utonsy findings available
2	ne ra e has age 2	Ĕ						autopsy perform	ned? death?	utopsy findings available completion of cause of
3	ificet or, pe	ပိ	25. Was case referred to medical				00 Plans of Dag	1 ☐ Yes 2	Λ	2 No
-	s cert	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	oc.		nce 6 Other (Spe	cultur)
5 8	orthi oral		27. Manner of Death	28a. Date of fnjury (Month, Day Year)	28b. Time o		y at	28d. Describe ho		ony)
5	ath. r: Att	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		fnjury		Yes 2 □No			
2	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R. State)	ural Route Number,
	rai Di	Cer								
	To the propriet or streaming ripsical. Within 24 hours else dead with this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exam	ysicien: To the best of my kr niner: On the basis of examin	nowledge, dea nation and/or in	th occurred at the tim	ne, date and place pinion, death occu	, and due to the ca rred at the time. da	use(s) and manner as	s stated. a to the cause(s)
	hin 2 the I	Ned	one)	and manner stated.						
, 1	1 × 0 0		29b. Signature and title of certifier	het H.D)	29c. License		_	d. Date signed (Mont	7
			a test	<u> </u>		Dia V	6060	1>	1/02/0	/
	10		30. Name and address of person who				is chi	8 000	1 2110	ELM 0 2070
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	M CHI	ノンドハ	NOND	LIVE	CL 11 0 10 10
	Registr		JAN 3 0 2	UU/ Kenne	H. I	Track D				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician U7AM Traynham lanuary 27 2007 F. /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Daltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 17 Yea*r)*18 Birthplace (State or Foreign Country)
 W V 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Days 1 □ M 2 □ F 88 216-62-7838 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Baltimore Director NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 U.S.A. "natural", or items 23a 4001 Cranston Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) House Homemaker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. Elizabeth Eubanks John Hymon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Briarleaf Ct, Catonsville, Md 21228 Nancy Glassha-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/07 Glen Burnie, Md Cedar Hill 21. Signature of Funeral Service Licer 22. Name and Address of Facility.
March F/H West 21215 Md Baltimore, 4300 Wabash Ave, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Un Knows Physician Autorioscleratic disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physician and 1 be detached for use as the bursel to the that initiated events resulting in death) Last certificate be exec Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Raynham, Kut Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 🗔 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? (Month, Day Year) or Attending 1 Natural R □ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Thomicide within 24 hours af

To the Funeral D

completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Eyen MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avene Baltimore Mony lan Registrar's Signature Berseron

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Tones

2007

			1- State of Maryland Department #19a Per INF G865 3/09/07	riment of H	lealth and Me Death	ental Hygiei Reg.	ne 200	7 02448												
	Physici /Medic		1. Decedent's Name (First, Middle, Last) VERNIE G. UMBERGER		2	2. Date of Death Month	Day Year													
	Examir		4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of Death Anne Hrun													
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	if Under 1 Year Months Days	-	B. Date of Birth (Month, Day, Yea	9. Bi	rthplace (State or Foreign												
h	Director		218-30-2361 1 96 Yrs.	Mar 10,		irginia														
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		· · · ·		10d. Inside City Limits												
	a-f sh	ctor	MD Anne Arundel Loth:	ian				1 ☐ Yes 2√ No												
	or 28	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What C	ountry?												
	eath v	Funeral	470 Sarah Anne Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	2071			USA 14. Race - Am	erican Indian												
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	þ	1 1 □ Never Married 2 □ Married 1 □ Yes 2 N No	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Specin, Mexican, Puerto Ri Specify:	can, etc.)	Black, Wh	ite, etc.												
15-0	"natu "natu edical	letec	(Specify only highest grade completed) (Give i	dent's Usual Occupa kind of work done o DO NOT use retired	durina most of working	16b	s/Industry													
212	be filed within 72 ho ntal Hygiene. od other than "natun event, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	acher	,		educatio	ation												
	al Hygie I other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maid														
ylai	should be and Mental s marked o umatic eve	卢	George Geordon			Virginia														
Maryland	ges 1 and 2 t of Health a If item 27 is or other tra	3	DECLIER		and Number or Rural ne Drive Lo															
Baltimore,			20a, Method of Disposition 20b. Place of Disposi		Da		Location - City o													
Baltir	permit. Pa Departmen Important: any injury once.		21. Signature of Euneral Service Licensee Ronald S. Wade Director St		es of Facility Omy Board MD 21201	655 W. B.	altimore	Street												
	Physician /Medical Examiner	ı	*23a. Part1 Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Jue to (or a a consequence of):			respiratory arrest,		Approximate Interval Between Onset and Death												
68760,	ficate be executed physician and is the burial-transit	al Examiner	Expurimently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	rahite	V		·	year												
_	#E 50 00	Medical	U				V													
.O. Box	The law requires that the death certif te has been signed by the attending age 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown			elivery Day Year														
rds, P.	w requires that been signed b should be deta	þ	þ	ρ	۾	۾	۾	۾	۾	þ	þ	þ	۾	۾	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause give	en in Part I.		o use contribute t	to the cause of death? Probably 4 DUnknown
or Vital Records,		Completed	24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 1 \(\text{Yes} \)																	
<u> </u>	Physician: this certificatal director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1	t 3 DOA Othe	26. Place of Death															
	Attending Phy ir death. ector: After thi by the funeral c	\vdash	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Injury		ne 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred															
Division	al or Atter s after dea tl Director ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	f. Location (Street City or Town, St	Location (Street and Number or Rural Route Number, City or Town, State)															
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invalid and manner stated.	occurred at the tim vestigation, in my of	ne, date and place, an pinion, death occurred	d due to the cause d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)												
	To the within To the Comp	M	29b. Signature and title of centifier	29c. License	2 1 4 3	29d. (Date signed (Mon	th, Day, Year)												
_			30. Name and address of person who completed cause of death (Item 23a) (Type, F		WAY Ar	V.N APOLL	Mo	21401												
	Sta Registr		31. Date filed (Morth, Day, Year) JAN 3 0 2007 32. Registrar's Signature	de la company de																

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and item 17 per fh 9863 1-30-07 yt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year OMe Januar 11:50 2007 /Medical 77 Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner on Memorial mol Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9-18-52 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 XM 2 □ F 216-50-1839 Director -18-52 Maryland Usual Residence of Deci permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any liquy or other traumatic event, the Medical Examiner must he natition of the propriet. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Funeral Director 1 Ser 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -lau 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Major Watson ဂ္ Barne. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iceA. salto MD 21212 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee en 1to.MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic dostructive pulmonary disease **Physician** disease or condition resulting in death) DYEORS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 Tyes 2 TNo the n signed by th. 1 be de⁺ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page certificate 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 1 ☐ Yes 1 Impatient P 2 ER/Outpatient 3 DOA After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 🗌 Yes 2 No within 24 hours after death To the Funeral Director; 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4.1 ans, MD Union Memorio 31. Date filed (Month, Day,- Year) State Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. ent's Name (First, Middle 2. Date of Death 3. Time of Death Month Year **Physician** January man regory 25,200 /Medical 4b. City, Townyor Location of Death, 4c. County of Death Name (If not institution, give ske Examiner gryland General Baltimon If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Months Hours Director Usual Residence of Decede the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Medical Exertmen must be notified at Completed by Funeral Director 1 **2**€es 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With USA Avenue or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates: 4 Divorced Blac 3 Widowed "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other then " College (1-4or 5+) Hract 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Williams ellie Parle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baldo MD 21212 20a. Method of Disposition Baltimore. 20b. Place of Disposition (Name cemetery, crematory or other 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 □Removal from State 5 permit. Page Department of Important: if eny injury or once. Mt. Zion Ceneter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee lu MD olk id Ba Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Com Immediate Cause (Final 11651 on **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 55tructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): for use as the buriai-transit Hospital or Attending Physician: The law requires that the death certificate be executed toistay Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. | funeral director, page 2 should be detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 (No 1 Dimpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No 24 hours efter death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completely it (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 3 30. Name and address of person who completed cause of death (Item 23a)-(Type, Print) laryland General Botwe M.0 neophilu 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 3 0 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician WOOKS IAN BARRI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number,) Examiner al HOSO, tal 7. Age (In yrs. last birthday) stord MOT Birthplace (State or Foreign Country) Number **Funeral** Min 213-68-100 M 2□F Days 1265 BIRTHORE, MI Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic avant, the Madical Examination and once. 1 Yes 2 Funeral Directo 0 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. þ 3 ☐ Widowed 4 Doivorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dausch oa. 0104 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) La. Informant's Name/Refationship (Type, Print) XI Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cometay, crematory or other place) 4 □ Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Forest Hill. enal Chapel & Cremo tion wans tun Approximate Interval Between Onset and Death 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is tonly ope cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner eman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner attending Physician: The law requires that the death certificate be executed the furieral director, page 2 should be detached for use as the burial-transit a Due to (or as 1 consequence of): 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 1 Yes 2 1 NO 25. Was case referred to medical examiner? 26. Pface of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 1 matient 1 ☐ Yes 2 ☐ No 3□ DOA Certification; To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Coufd not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20211

State Registrar

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DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2007

NOW.

31. Date filed (Manth Day)

601.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Year Month 01 **Physician** Ruth M. Williams 26 4:50p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9403 Avenel Rd. Montgomery Silver Spring 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F 92 Days Hours 119-28-7753 Director 12-30-1914 Jamaica Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Montgomery Silver Spring death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? al Hygiene. other than "natural", or items 23a or ivent, the Medical Examiner must be r 20903 USA 9403 Avenel Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or ite ury or other traumatte event, the Medical Examinea ury or other traumatte event, the Medical Examinea 1 ∏ Yes 21<u>X</u> If Yes, Give Year or Dates: 1 Never Married 2 Married 2K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black ģ 3XXVidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Aide Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Douglas Esther Davidson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Williams/daughter 9403 Avenel Rd. Silver Spring MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 01/31/2007 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility Rapp Funeral & Cremation Service M00382 The A policine 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a d be detached f 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performe 2K No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ျှ 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury s after death.

I Director: A
id in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

P.O. Division or Vital Records, within 24 hours at To the Funeral Completely filled it

> State Registrar

6

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Charles L. Franklin MD 11120 New Hampshire Ave #408 Silver Spring MD 20904

29c. License number

4400

29d. Date signed (Month, Day, Year)

			1 - State of Maryland / D		lealth and M		2007	02453			
I	Physici		1. Decedent's Name (First, Middle, Last) Mary Margaret	Wilson	Jilson Jan. 28, Day 2007 Year 10:00 F						
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 469 New York Avenue	venue Pasadena							
	Funeral Director		5. Social Security Number 220-38-5908 0. Sex 1 M 2 F 7. Age (In yrs. last birth)	thday) It Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Ye Sept 29,	9. Birti 2941 Ma	nplace (State or Foreign untry) aryland			
	Maryland -f ehow iled al	tor	10a. State 10b. County 10c. City, Town Maryland Anne Arundel		asadena		10d. Inside				
	h with the 23a or 28a lat be noti	ai Director	10e. Street and Number 469 New York Avenue	10f. Zip Code	21122		Citizen of What Co USA	untry?			
036	within 72 hours after death with the Maryland ene. than *neturel', or items 23a or 28a-f ehow the Mudical Exate ar must be notified a	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 12 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Amel Black, White Specify: W				
Maryland 21215-0036	within 72 ho lene. than "netur the Mudical	Completed	(Specify only highest grade completed)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired Clerk	during most of work	ng I	Motor Veh Administr	icle			
land 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f ehow any injury or other treumatic event, the Martical Exandract must be rediffied at once.	To Be C	17. Father's Name (First, Middle, Last) Charles Mosmil	ler		<i>(First, Middle, Maid</i> Mary Flaha					
, Mary				Mailing Address (Street a			•				
Baltimore,		2	1 Burial 2 Vi Cremation 3 Bernoval from State	Disposition (Name of y, crematory or other place ew Crematory	y, Inc. 1	/31/07 Ba		Maryland			
Ä	Ped mine on the contract of th		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	22 Marrie and Addres MCCully—I 3204 Mour not enter the mode of dying	ntain Rd.	Pasadena or respiratory arrest,	a, Md. 2	Approximate Interval Between			
. Box 68760,	Physician /Medical Examiner per partial-transit Physician and physician and physician and physician phys	licai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Liver To Due to (or as a consequence of the conditions of	<u>S</u> or):				Onset and Death Months			
	thet the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year							
	The law requires that the law sequires that the has been signed by the hage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in	co use contribute to	the cause of death?						
Vital Records,	G 77	Completed				24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of			
	Physician: The string of this certificate brail director, page	To Be	27. Mann Death 28a. Date of Injury 28b. T	tpatient 3 DOA Other	er: 4 Nursing Ho	me 5 V esidence 28d. Describe how i		sify)			
Division of	To fire Hospital or Attending Physicin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	1 Vatural 5 Pending (Month, Day Year) Ir 2 Accident 3 Suicide 4 Homicide (Specify)	M 1 🗆 '	ork? □Yes 2 □No			ral Route Number,			
	Hospital 24 hours a Funerel E Interly filled i	edicai Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time	ne, date and place, pinion, death occurr	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
	To the comp	Me	29b. Signature and title of certifier	MD 29c. License			Date signed (Month				
	<u>b</u>		0. Name and address of person who completed cause of death (Item 23a) (CON FAX Kieding Er 860 Ver 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Type, Print) Lerans Hw	y Mille	ers v.11	e, MU	21108			
DH	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) 32. Tegistrar's Signature	Apriles U			100.00				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9.158 ANUAZY 2007 Romona Wojick 25 Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN BURNIE ANNE ARUN DE WARHINGTON MEDICAL CENTER Aftimoras ff Under 1 Year Months Days | ff Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct. 23 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 V F 78 216-24-3012 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Anne Arundel Millersville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8244 Elvaton Road 21108 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married RAMONA J. WOJICK Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Air Freight Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mentel Andrew J. Yowell ပ္ Josephine R. Denton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8244 Elvaton Road Millersville, Mr. Owen Wojick /Son MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 30, 20c. Location - City or Town, State 20a. Method of Disposition 0 = 1

Burial 2 □ Cremation 3 □ Removal from State 2007 Marriottsville, MD 4 Donation 5 Other (Specify) Crestlawn Mem. Gardens 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral Home, P.A. Lidense 1 Second Avenue Sw Glen Burnie, MD 21061 23a. Part . Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physicien: The law requires that the death certificate be executed C12240515 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, STRUCTURE TULMOMARY Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Inknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cete has l certificete 1 Yes 2 No Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 Yes 2 No 1 Inpatient မှ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29c. License number 9d. Date signed (Month, Day, Year) 2 MD 30 Name and address of person who completed cause of death (Item 23a) (Type, Print 30 L WX OUGLE Wal 31. Date filed (Month Day, Year) 2. Registrar's Signature State Registrar 2007 0

5:15 A.M.™

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 □Yes 27 No

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

January 17, 2007

Year

Minnesota

14. Race - American Indian,

White

Specify:

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Assisted 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one), and manner stated.

after death.

within 2

Registrar

Certification: To

Medical

29b. Signatur

and title of certifier

Raffel, D.O., F.A.C.P., 5411 W. Cedar Lane #202A, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32 Registrar's Signature-JAN 3 0 2007 alus-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

H45839

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Wallace 8:00pm James, Edwin lanuary 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALLIMORE VAMEDICAL Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Ye 07/30/1926 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Hours 217-20-7494 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir Items 23a or 28a-f ahow instraust be notified at MD Director Baltimore N Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1635 Moreland Avenue 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑(Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify African Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th roofer White Roofing Co. other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental I snt: If item 27 is marked o James Wallace Mary White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Wallace / Wife 1635 Moreland Avenue; Baltimore, Maryland 21216 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. 02/02/2007 Owings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mocardia /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that with the cause). Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) detached ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an No 1 Tes 1 Yes 2/2 completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7540 M030. Name and address of person _____mpleted cause of d_ath (Item 23a) (Type, Print) 10 N. Greene St. Baltimore, MD 21201 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

JAN 3 0 2007

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Young, Sr. **Physician** David 11:45p M 2007 24 1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore 2423 A Lincoln Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 11 25 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Months Hours 1 X M 2 □ F Yrs 32 VW 74 Director 219-30-0049 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1X Yes 2 No **Funeral Director** Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219 U.S.A. 2423 A Lincoln Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 🎇 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Truck Company 9th grade nă 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Colonel Roosevelt Young Sr. Mammie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2423 A Lincoln Ave, Baltimore, Md 21219 Ruth B. Young-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/30/07 Randallstown, Md March F.H. East West 21215 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 9300 Wabash E. North Avenue, Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Ö 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 3 Probably 4 □Unknown 1 Yes 2□ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 219 No 2 ☐ ER/Outpatient 3 DOA ۲ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☐ Matural Medical Certification: Injury 5 Pending investigation 1 TYes 2 No within 24 hours after death. To the Funeral Director: 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certific

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amend item 22 per fb 8863 1-30-07 vt. State of Maryland? Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar Theodor

31. Date filed (Month, Day, Year)

IAN 3 O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

texheni

1005

32 Registrar's Signature

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	Physici		1,201.02								2007	12:55Pm			
	/Medic Examin		4a. Facility Name (If not institute 208 S. Patter					4b. City,		Location of Balt:)		ty of Death	City
Ī	Funeral Director		5. Social Security Number 055.30.4602	6. Sex		Age (In yrs. 70	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 04/1	936	9. Birthp Cour Fran	place (State or Foreign ntry) CE
	yland sow		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. Cit	y, Town or Lo	ocation						1	10d. Inside City Limits
	8a-f et	ector		timore	City	Ва	ltimor		Codo				10g. Citizen of	What Cour	1 Yes 2 No
	3a or 2	I DI	10e. Street and Number 208 S. Patter	son Pa	rk Ave	nue		10f. Zip	231				USA	Wilat God	,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other then "natural, or Items 23s or 28s-f show early injury or other traumatic event, the Medical Examinar must be multiled at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mi 3 □ Widowed 4 □ Divorce	arried 1	Vas Deceder Irmed Force: Yes 25 Yes, Give Year or Dates	No		Was Deced If Yes, spec 1 ☐ Yes	cify Cuba	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	BI	ace - Americ ack, White, ify: Wh i	etc.
Maryland 21215-0036	within 72 hounds.	Completed	10. Dooddon o Eddadnon						Kind of Business/Industry spital						
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Mary	nd 2 shou Ith and M 27 ie mar r traumat	-	19a. Informant's Name/Relatio Noele Zeltzmar		Print)							Avenue			Code) MD 21231
Baltimore, I	Pages 1 an nent of Heal ant: if item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ € remation 4 ☐ Donation 5 ☐ Other		val from Sta		Place of Disponentery, cre	matory or o	ther plac		Inc.	Jan 30 2007	20c. Location	•	own, State Maryland
Balt	permit. Departr Importe eny inju		21. Signature of Funeral Service	e Licensee	this	10 14						l Alterr Drive F		re, Mai	ryland 21286
760, Y	Physician /Medical Examiner	ilcal Examiner	23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b c d	Due to (or a	as a consequence as a c	uence of):			M /	MG.	45			Approximate Interval Between Onset and Death
.O. Box 68	thet the death certifica ed by the ettending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		f yes, outcon I □Live birth I □Pregnant	2 □ Feta at time of d	I death 3	□Ectopic pi □ Other (sp						ate of deliver	ery Day Year
<u> </u>	8	by	Part II. Other significant cond	tions contribu	uting to death	but not res	ulting in the u	inderlying o	cause give	en in Part I			obacco use co (es 2□No		he cause of death?
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Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medi examiner?	Hosp	ital: 1 □ Inpa	atient 2 🗆	ER/Outpatie	nt 3□ D0	Oth	or		me 5 Resid		ther (Specif	fy)
ion of	ding After fune		27. Manyer of Death 1 Natural 5 Pen 2 Accident inve	stigation	8a. Date of Ir (Month, I		28b. Time o Injury		28c. Injun Wor			Home 5 Pasidence 6 Other (Specify) 28d. Describe how injury occurred			,,
Division	s after death s after death st Director: ed in by the	Certification:	3 Suicide 6 Cou	mined 2	8e. Place of building,	Injury - At ho etc. <i>(Specif</i>	ome, farm, st y)	reet, factor	y, office			28f. Location (S City or Tox	Street and Nun yn, State)	nber or Rura	al Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 111948, per FH, C863, 1/31/07, WS
State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month January 25, 2007 Physician EUL FINDErson /Medical Examiner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death laryland General Hospital Baltimore ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1907 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 0 2/5 05 6989 Usual Residence of Decedent Director 215 2007 VILGINIA 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 29s-f show other treumstic event, the Mudical Examinar must be notified at Yes 2□No Director Balhmore Morylass 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Andleson 2/2/7 USB 1505 DRUSID HILL To Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify Black 3€Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Private Iwarty Efementary/Secondary (0-12) College (1-4or 5+) Alteroand Bar permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygien important: If tem 27 is marked other th any njury or other treumatic event, Lta. ADGS. Worker 312 grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Brown UNK: Unt. 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BANKS DAI TRUCK, 59 48 SONNYCAKE Kd Med 21287 Marjorie C., 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State NAtional Voltinor, Pamylows 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licersee teneral Hone CHATHAR- HAMI 22. Name and Address of Faculty 5240 ICON Turkou ld Balhner. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition as the cause of each line. Approximate Interval Between Onset and Death Physician /Medical resulting in death) Top to (or as a consequence of): Examiner Insufficiency Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner pertension Attending Physicien: The law requires that the death certificate be executed use as the buriai-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 4 Pregnant af fime of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cete has been signed by the page 2 should be deteched 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1 🗆 Yes 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Funeral Director: After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🖺 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after 4 Homicide 29a. Certifier 16 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 112510 30. Name and address of person who completed cause of dealth (Item 23a) (Type, Print) Haalan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. americal item 29d per dvr 9863 1-31-07 vt. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #19a, perFH, G864, 2/1/2007 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month **Physician** 24,2007 Januar Dorothy Frances Amrhein /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5000 Samar Itar Baltmore
If Under 1 Year | If Under 24 Hrs. OITAI 8. Date of Birth (Month, Day, Year) June 30, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🕱 F 90 1916 Maryland 217-18-1743 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21206 United States 4602 Seifert Avenue 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) natural', or itsms 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ¥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antoinette Stach Henry Huemmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health i Baltimore, Amrhein / Daughter 4602 Seifert Ave. Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 01/29/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensep 22. Name and Address of Facility 5305 Harford Road Michael E. Canapp Baltimore, MD 21214 Leonard J. Ruck, Inc. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Otheroschautee Cardiovascular desas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 99 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1□ Yes 2☑ No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D2 8987 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

CARL SPERLING

31. Date filed (Month, Day, Year)

JAN31

2007

BALTO.

MD 21239

5601 LOCH RAYONBLUD

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Adcock 26,2007 Year **Physician** Loretta 2:05 P January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Eastpoint Eastpoint Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Yrs. Virgínia Director Jan. 20,1934 215-30-1153 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2 No iral", or items 23a or 28a-f sh Examiner must be notified Baltimore Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7805 St. Boniface Lane United States 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛂 No Baltimore, Maryland 21215-0036 þ Specify. XX Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 10 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lilly Randolph Oscar Fridley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Son) Michael Adcock 7805 St. Boniface Lane Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or oti 1 Burial 2 □ Cremation 3 □ Removal from State Hill Mem. Gdns. 1/30/2007 Middle River, MD 4 Dopation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 ral Service Signature u Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Heart failure **Physician** disease or condition resulting in death) /Medical **Examiner** Artery orunues Sequentially list conditions, if any, feading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner I or Attending Physiclan; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 pronths? 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ valvolar Heurt Disease 1 Yes 2 No 3 Probably 4 Unknown Be Completed Diabetes Mellitor 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes Vascular Dementia 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this nours after death.

Ineral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D39660 Somet Deut . Mis Durwung 29, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimare 15cele North Point - Dant 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harold William Albrecht 0656 AM 2007 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner agnes Hospita MIMOURE If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea APR 7, 19 5. Social Security Number Age (In yrs. last birthday) /ear 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1₩ 2□F 85 Yrs 391-12-0468 1921 Wisconsin Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits rthen "natural", or Items 23a or 28a-f ehow the Medical Examiner must be codified at 1 ☐ Yes 2 TNo Director MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane, PV-410 21228 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1♥Yes 2□No IfYes, Give Year or Dates: 41-45 l lo 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) <u>Accountant</u> <u>Baltimore City</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Arthur W. Albrecht Ella E. Ihlenfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pormit. Pages 1 and 2
Depertment of Health an Important: If Item 27 is meny injury or other Florence Albrecht/Wife 715 Maiden Choice Land PV 410 Catonsville, MD 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 1/29/07 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause op each line. iterval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last .O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending P within 24 hours after death.
To the Funerel Director: After the completely filled in by the funera 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or

State Registrar 31. Date filed (Month, Day, Year) Calon 32. Registrar's Signature

29b. Signature and title of pentifier

of death (Item 23a) (Type Print)

29d. Date signed (Month Day, Year)

			1- For State of Maryland / Registrar	Depa	rtment of H	ealth and M			02404
			Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physici /Medic		JEANNINE LOUISE BYRD				Tán wa	Day Year	7 1:25 AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
è,			Franklin Square Hospital 5. Social Security Number 6. Sex 7. Age (in vrs. last b	h iveth alon ()	If Under 1 Year	If Under 24 Hrs.	2 Data of Birth	1201	-imore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 80 (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 4,	Year) 9. Bir	thplace (State or Foreign ountry) IShington
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	larylar show	o.	10a. State 10b. County 10c. City, To						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N 28a-f notifie	Director	Maryland Baltimore Ba	arrri	nore Coun	ьу	11	0g. Citizen of What C	
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	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-	14. Race - Ame Black, Whi	
30	s after		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1	☐Yes 2 No	Specify:		Specify: Wh	
3	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	···	a. Deced	ent's Usual Occupa	ation	- 1	16b. Kind of Business	
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land	l be fil ntal H ed oth even	Be	17. Father's Name (First, Middle, Last) George Kling			18. Mother's Name Viola		Maiden Surname)	
\geq	should and Men s marke umatic	ဥ		9b. Mailin	Address (Street a			City or Town, State,	Zin Cada)
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gal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Letter see	²² 7	Name and Address assann Fi 401 Belai	sofFacility Ineral Hom ∟r Rd. Bal	ne Ltimore,	Maryland	21236
L	-		23a. Party forter to disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	r the mode of dying	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
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ה מ	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 1 ☐ Hallow Dirth 2 ☐ Fetal death		Ectopic pregnancy Other (specify)			Month	Day Year
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VII S	lan; Trifficat	Be C	25. Was case referred to medical			26. Place of Death		P No 1 □ Yes	2 □ No
> 10	ا ق <u>ک</u>	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 PER/O	utpatient	Other	r·		nce 6 ☐Other (Spe	ecify)
	Ing Ph		1 Natural 5 Pending (Month, Day Year)	. Time of Injury	28c. Injury Work		8d. Describe ho	w injury occurred	
DIVISION	death death ctor: y the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home. f	farm, stre		es 2□No	8f Location (Str	eet and Number or R	ural Pouto Number
2	al or / after il Dire	ertii	4 Homicide determined 28e. Place of injury - At home, f building, etc. (Specify)	,	-,,	1	City or Town	, State)	urai Floute Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Lertifying Physician: To the best of my knowledge Medical Examiner: On the basis of examination and manner stated.	ge, death and/or inv	occurred at the time estigation, in my op	e, date and place, a pinion, death occurre	and due to the ca	ause(s) and manner as ate and place, and du	s stated. e to the cause(s)
	o the	Mec	29b. Signature and title of certifier		29c. License	number	29	9d. Date signed (Mont	th, Day, Year)
			> /// R//		DS	442	8	1/30/	37
	5		30. Name and address of person who completed cause of death (Item 23a) MICHAEL RIA MO 90 C F 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 3 1 2007	(Type, F	Print)	. , , , ,	0 .	1 -	1.0
		•	31. Date filed (Month, Day, Year) 32. Registrar's Signature	CAN	Klin Sq.	were Dri	ve Bal	timore M	1021237
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			Unit of the Court	-	CAR SHITTER STREET				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year 0 25 0300 AM ZOOT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary Bal University

5. Social Security Number land Med. (enter timore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday 1 ☐ M 2 🗓 F Days Hours 214 48 0108 59 Director Feb. Maryland 8. 1947 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-4 ehow 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Maryland Baltimore Essex 1 ☐ Yes 2 X No Director 10e. Street and Number 951 Barron Avenue 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Nidowed 4 Divorced Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0wner Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Butler ပ <u>Mary Calhoun</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donovan Bolen / Son 951 Barron Avenue Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD. State Veteran Cem.1/30/2007 4 Donation 5 Dother (Specify) Crownsville, Maryland ²² Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Linense 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ischemic disease or condition resulting in death) cardiomyopathy inknowr /Medical Due to (or as a consequence of): myocardalal Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached it 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ို 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) street Green 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 3 1 2007

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** Bolden 14:25 PM Arvell January 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City 7. Age (In yrs If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□F Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23s or 28s-1 show traumstic event, the Medical Examiliar most be notified at 1 Yes 2 □ No **Funeral Director** more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2431 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 31ac "nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOTUSE retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be laine Chase 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2431 Date 20c. Location · City or Town, State 20a. Method of Disposition permit. Pages Department of Important; if it eny injury or o 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 28. Name and Address of Explity Uu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Balto. MD Id. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulseless Electrical Activity Cardiac Arrest **Physician** 24 hours /Medical Due to (or as a consequence of): Examiner 25 hours Hypostycemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DISCUSE End Stage Liver 10 years attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☐ Unknown 2 X No 1 🗌 Yes this certificate has been siral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital Certifying Physician: To the hest of my knowledge, death construct at the time, data and plana, and this cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J, Medical Doctor es-000 January 19, 2007 luga 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miya Pakernifi, The Johns Hopkins Hospital, 400 Morth Worle Street, Baltimore, Maryland 21287 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 3

1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Kathleen Boyd 29 2007 /Medical January 3:07 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Months Days Hours 214-20-3593 Director 84 1922 DEC 13, SC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 268 Chestnut Street 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 XNo Specify 3 Widowed 4 □ Divorced **Black** Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Lee Delia ٩ Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwayne Boyd - son 268 Chestnut Str<u>eet, Dundalk, MD 2122</u>2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Metro Crematory, Inc. 1/31/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee ²²CName and Address of Facility Cremation Society of Maryland, Inc. Steven H. Williams 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** 49shaintestmal weeles disease or condition resulting in death) /Medical tue to (or as a consequence of): Examiner ervical cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last month Physician/Medical Examiner Due to for as a consequence of law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day 5 Other (specify) been signed by the s should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No al or Attend s after death il Director: / 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the Laminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 29 2007 58303

Registrar

State

31. Date filed (Month, Day, Year)

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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St Buthwe MD 21204

		4	For State Registrar	State of	Marylar		artment of H <i>tificate of L</i>			giene. U Reg. No.	0 1	02400	
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			5. Social Security Number 6.5			last birthday)	If Under 1 Year	If Under 24 Hrs	s. 8. Date of Birth		9 Birtho	lace (State or Foreign	
ч	Funeral Director			I □ M 2 【XF		+6 Yrs.	Months Days	Hours Min	Month, Day Dec 28	, Year) 1960	Mary 1	try)	
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Maryland 21215-0036	ss 1 and 2 should be fi of Health and Mental H item 27 is marked ott r othar traumatic evar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a				n, State, Zip	Code)	
	and 2 naith a n 27 is ar tra		Virginia Lednum	Mother			Telegraph			vern, l	Maryla	nd 21144	
ore		l i	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from St			sition (Name of matory or other place		Date	20c. Location			
Baltimore,	Page ment ant: if		`4 ☐ Donation 5 ☐ Other (Speci	fy)	Met		ematory In		′30/07			Maryland	
Bal	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Servey Control of F	X-		2	remation 199 Freder	Society ick Ros	of Mary d Baltim	land, ore, M	Inc. arylar	d 21228	
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Вох	death certifi e attending i d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live birt	h 2 Feta	aldeath 3□	Ectopic pregnancy Other (specify)				Date of delive Month	Day Year	
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lon	th. : After s funer	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	f 28c. Injury Work M 1 🗆 `	:? ∕es 2 □ No					
Division of Vital Records,		Certification;	3 ☐ Suicide 6 ☐ Could not I	289. Place 0	Injury - At h	iome, farm, str fv)	eet, factory, office		28f. Location (S City or Tow		nber or Rura	l Route Number,	
Ö	To the Hospitel or A within 24 hours after To the Funeral Dirac completely filled in by		29a. Certifier 1 ☐ Certifying P	hysician: To the b	est of my kn	owledge, deat	h occurred at the tim	e, date and plac	e, and due to the	cause(s) and r	manner as st	ated.	
	n 24 h	edical	(Check only 2 Medical Exa	miner: On the bas and manne	is of examin	ation and/or in	vestigation, in my or	oinion, death occ	curred at the time,	date and place	e, and due to	the cause(s)	
Signature and title of certifier 29c. License number 29d. Da									29d. Date sign		Day, Year)		
	Λ		1	w Day				95			5/07		
	5		30. Name and address Person who	completed cause	of death (Ite	m 23a) (Type,	Print)	C# 5	(/\^\	<i>T.</i>	70 ti	HOCIE GN	
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Sign		nache)	3/ 33/	12 700	100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	V 21204	
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State of Maryland / Department of Health and Mental Hygiene UU

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:15 a^M Maggie Roof January 24 2007 Byrd /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 59 Ferns Way Drive Nottingham Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Yrs. Director 212-32-1361 101 DEC 31. 1905 Virginia Usual Residence of Decedent e filed within 72 hours after death with the Maryland if Hygiene.
other then "natural", or items 23e or 28e-1 ehow 10b. County 10c, City, Town or Location 10a State 10d. Inside City Limits ral, or items 23s or 28s-f show Exeminer must be notified at 1 ☐ Yes 2 XNo Directo MD **Baltimore** Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 59 Ferns Way Drive 21236 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Nurse <u>Hospital</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 is marked ott Be 2 Unknown Jackson Manurva Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amia Brown - granddaughter 59 Ferns Way Drive, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State permit. Page Department of Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/29/2007 Baltimore MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) Physician Uterine Cancer year /Medical Due to (or as a consequence of) Examiner cachexic - with failure to thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit osteoporosis yrs Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physicien dementia mild Physician/Medical the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ž 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ormed? 2∭No certificate 2□ No 1 ☐ Yes 1 ☐ Yes After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 X Natural Injury 1 Yes 2 No i Director: 2 Accident 3 Suicide 6 Coufd not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide To the Funeral 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D54749 January 24, 2007 30. Name and address of person who completed cause of death (Item 2 1) (Type, Print) Allen Reilly, MD 801 Toll House Ave, Suite D-1, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of	Marylan		artment of rtificate of				jiene	7	02470
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/Medi		4a. Facility Name (If not institution		ber)		4b. City, Town,	or Location of	of Death	Jan 27,	2007 4c. County	of Death	0-01 11
LAGITIII	ICI	Ivy Hall Nursi	ng Home			Middle	Rive	r		Balt:	imore	
Funeral		5. Social Security Number		'. Age (In yrs.	^	If Under 1 Yea Months Day:		24 Hrs. Min.	8. Date of Birth (Month, Day) Nov 29,	, Year)	9. Birthp	place (State or Foreign ntry)
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To th within To th comp	Me	29b. Signature and title of certified		1/2		29c. Lice	nse number		2	9d. Date signe	d (Month,	Day, Year)
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4		30. Name and address of person	who completed cause	of death iften	n 23a) Typo.	Printy AN	· An	75	An	217-	21	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** DOROTHY HOWELL CHAMBERS 8:17A M JAN 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 8400 GREENS LANE RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 74 Director 246-38-9404 01/29/1932 CAROLINA N. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐Yes XXNo notified Director MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? ò 8 8400 GREENS LANE 21244 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 1 ∏Yes 2 X No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ed other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NEW YORK CITY Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M CLERICAL 12TH DEPT. OF RECREATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT GASKINS 2 OLA HOWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 2 4 4 19a. Informant's Name/Relationship (Type. Print) SANDRA CHAMBERS / DAUGHTER 7226 STONEY BARR RD., WINDSOR MILL, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1**X** Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (*Specify*) KING MEM. PARK 2/03/07 WINDSOR MILL, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final dis the or condition resulting in death) **Physician** NAC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed l B Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has be inector, page 2 s autopsy performed 2-No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1-Natural 1 Yes 2 No 2 Accident il Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar amin

31. Date filed (Month, Day, Year)

MA

32. Régistrar's Signature

11

07-00781 Mary Carrier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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<i>y</i>		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Ļ	3309 Woodstock Avenue Baltimore	
Funeral Director			(State or ryland
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ir	nside City Limits
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r death with the Maryland or items 23a or 28a-f show any must be notified at once.	<u> </u>	10e. Street and Number 3309 Woodstock Avenue 10f. Zip Code 21213 10g. Citizen of What Country? USA	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Manal Hygiene. The strict of Health and Manal Hygiene "matural", or items 23a or 28a-fishe or other traumatic event, the Medical Examiner must be notified at once	Laue	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes, Give Year 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Specify	
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		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr 263 S. Conkling St., Baltimore, MD	
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To the Hos within 24 h To the Fur completely	<u> </u>	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b Signature and title of gertifier 29c License number 29d Date signed (Month, Day	
a '		O.C.M.E. January 29, 2007	r, rear)
5	1	30. Name and address of person who completed cause of death (Item 23a)	
Stat		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature. 32. Registrar's Signature.	
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State of Maryland / Department of Health and Mental Hygiene U U / Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23° **Physician** 7:20 A. M January Margaret E. Critchlow /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie Glen Burnie Health & Rehab. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 20, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛛 F Ï918 Pennsylvania 178 12 7733 88 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28e-1 show any injury or other traumatic event, the Medical Examinat must be notified at 1 Yes 2X No Glen Burnie Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21060 7210 Crown Road Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Amed Folces: 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Snyder Mabel Lynch ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, Maryland 21060 Betty Davis / Daughter 7210 Crown Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State State Veteran Cem. 1/26/2007 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway manue 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMER'S DUEASE Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 mo ths? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificete 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient ို 3□ DOA Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Funeral 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 2 within 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2 2007 puragene, mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDHARMASEM, MOD. BALT POTER ST. 1MORE, MD 2/220

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 1

2007

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32 Registrar's Signature

07-00496 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brenda Collington State of Maryland / Department of Health and Mental Hygiene 2007 1- For State Certificate of Death Reg No Registrar 2. Date of Death cedent's Name (First, Middle,Last) Physician/ Brenda Collington Month Day January 18, 2007 Medical Examiner 1202 hrs 4a. Facility Name (if not institution, give street and number) 7200 Donnell Place #D-2 Forestville Prince George's 7 Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 8irthplace (State or **Funeral** 579-72-0528 Country) DC Months Days Hours Min Director 07-02-1955 51 M 2 XF Usual Residence of Decedent anv 10a State 10b County 10c. City, Town or Location 10d Inside City Limits MD Prince Georges Forestville Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other rraumatic event, the Medical Examiner must be notified at sone. 1 Xyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Donnell Place #D2 20747 USA Funeral 14. Race - American Indian, 8 lack, 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married Yes If Yes, Give Year Yes 2 X No specify Specify: Black Widowed Divorced ş r Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry leted Elementary/Secondary (0-12) College (1-4 or 5+) Enviormental Specialist Government Comp 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Melvin Freeman, Sr. Shirley Kimbles Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Carol Cole 6109 Spell Rd Clinton, MD 20735 Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 ABurial 2 Cremation 3 Removal from State 1/26/2007 Suitland, MD Cedar Hill Cemetery Donation 5 Other Specify 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bianchi 814 Upshur st NW Wash, DC 20011 23a Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure List only one cause on each line. 8etween Onset and /Medical a. Gunshot Wound of the Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last /_{pg} sician/Medical UNPENDED AMENDED attending physician or use as the burial certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day 2 past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 V Unknown icate has been signed by the att page 2 should be detached for Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✔ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical the Hospital or Attending Physician: hin 24 hours after death. uneral director. 26. Place of Death (Check only one) Be Other₄ Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 Yes 27 Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot FOUND: Natural 5 Pending Yes 2 V No the To the Funeral Director: Jan 18, 2007 1145 hrs Investigation Accident pletely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town determined 7200 Donnell Place #D-2, Forestville, MD (Specify) Residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. January 19, 2007 0 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

JAN 3

Physician /Medical Examiner Division or Vital Records, P.O. Box 68760 or Attending Physician: within 24 hours after death To the Funeral Director:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Damoval from State	20b. Place of cemeter	Disposition (Name v, crematory or oth	of erplace)	Date	20c.	Location -	City or Tov	vn, State	
	4 □ Donation 5 □ Other (Specify		HAR SI	NAI CONG.	ģ	1/30/2	:007 OW1	INGS M	1ILLS	, MD	
	21. Signature of Funeral Service Licer	isee		22. Name and	Address of Facili	ity SOL	LEVINSO	ON & E	ROS.	, INC.	
	150000	X	<u> </u>	8900 F	EISTERS					MD 21208	}
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each line	he death. Do n	ot enter the mode	, 0,	s cardiac or re	,			Approximate Interval Between Onset and Death	1
	disease or condition resulting in death)	a. Due to (or as a	consequence o	f):					(Junes	_
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	resulting in death) Last	Due to (or as a	consequence o	f):							
,	IF FEMALE: 23b. Was decedent pregnant in the past 12 poonths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pr 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic preg 5 □ Other <i>(sp</i> ec				23d. Dat Moi	te of deliver	ry Day Year	
	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cau	se given in Part	1.	23e. Did tobacc			e cause of death? ably 4 □Unknow	/n
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	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	e 28e. Place of injun building, etc.	y - At home, far <i>(Specify)</i>	rrı, street, factory, o	office	28f.	Location (Street City or Town, St		er or Rural	Route Number,	
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	29b. Signature and title of certifier	y Mil	y . au	0	icense number	15		Date signed		P, 2007	,
	30. Name and address of person who	completed cause of dea	eth (Item 23a) (Type, Print)	St.	Bali	to. ind	21	204		

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32 Registrar's Signature

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		•	For State Registrar	State of M	arylan	-	artmen tificate			and M	lental		ene () ()	7	0247	17
	Physici	an	1. Decedent's Name (First, Middle, La Marion Bertha Ca								2. Date of Month		Day 2007	Year	3. Time of D 9:30 a	
	/Medic		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of		Jan.	22,	4c. County	of Death		1.111.
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3	Funeral Director		212-20-7879	Sex 7. Ag	je (in yrs. i	o Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month) Feb	f Birth $(Day, 1)$	1926	9. Birth Cou Ma	place (State or I ntry) aryland	-oreign
	and and It		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation								10d. Inside City	Limits
	Mary e-f sho	to	MD Baltimo	re	Lu	thervi	11e								1 ☐ Yes 2	No
	or 286	Sirec	10e. Street and Number				10f. Zip						g. Citizen of W	hat Cou	ntry?	
	s 23a	rai	1204 Scotts Knol	1 Court	Francia III	6 42.1	210		i- Ori	-i-2 (Ca	asit. Vas		J.S.A.	- Amari	can Indian.	
920	n 72 hours after death with the Maryland "natural; or items 23a or 28e-f show solical Expenies must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	•		Was Deced f Yes, spec 1 ☐ Yes :		Specity:		Rican, etc	.)		k, White		
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ylar		ToE	John Harrer								Getzi					
Maryland	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relationship Kathy Simmons,				-						City or Town, erville		_	3
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	Physician /Medical		dise se c condition resulting in death)	a CARI	DIO P	ULMU	NAME	1 A	RRE	TT				-	INSTA	701
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Вох	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	Ideath 3[DEctopic pr	egnancy					23d. Date Mor		ery Day Ye	ar
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Ω.	de de		Part II. Other significant conditions	contributing to death I	out not rest	ulting in the u	nderlying c	ause give	an in Part I		23e.	Did toba	acco use contr	ibute to	the cause of de	ath?
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	To the Hospital or within 24 hours after To the Funerel Dii	edicai	(Check only 2 Dedical Exa	miner: On the basis of and manner s	of examina	tion and/or in	vestigation	, in my of	pinion, dea	ith occur	red at the	ime, da	te and place, a	and due	to the cause(s)	
	To the Vithin 2 To the Complet	Me	29b. Signature and title of certifier	111			290	. License	number			29	d. Date signed	(Month	, Day, Year)	
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	5		30. Name and address of pe n		death (Item	23a) (Type,	Print)	2.00	a	×	1,0	1.		M	12126	/
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 🖺 🖺 Certificate of Death Reg. No. 3. Time of Death A 2 Date of Death Decedent's Name (First, Middle, Last) **Physician** 24,2007 c. County of Geath anuary /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner lanor Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign If Under 1 Social Security Number 7. Age (In yrs. last birthday) Maryland 212-26-3987 Usual Residence of Decedent 1□ M 21 F Π 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director more 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Blac ρ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) useKeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William 19a. Informant's Name/Relationship (Type, Print) 3 2 4 4 5 7 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) armel Joseph L. Russ Fun 2222 W. North Ave. 21. Signature of Funeral Service Licensee 23a. Parti Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA STAGE CND month disease or condition resulting in death) Due to (or as a consequence of) MONTER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

Examiner requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After th
completely filled in by the funeral

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Madical Examinar rought to multified at

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Physician

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Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

00053150

SANTIAGO NO

MO WOUS

COLUMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ShAWN MACA

State Registrar

31. Date filed (Month, Day, Year) 2. Registrar's Signature JAN 3 1 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:38PM 28 lanuary 2007 Earl /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns Hookins Bayrin Hedical Centr Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1**∑**M 2□F 59 Maryland 216-54-5161 September 1,1947 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Dundalk Baltimore 1 ☐ Yes 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21222 2243 Searles Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 vears Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (2 William H. Dennis Sr. Amelia Kerner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Dennis 2243 Searles Road, Dundalk, Maryland 21222 wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk, Maryland 2007 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 2 Signature & Funeral Service Licen e Approximate Interval Between Onset and Death 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pulmonary
Due to (or as a consequence of): Embolism 5 days disease or condition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an erformed 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and Division or Vital Records, P.O. Box 68760,

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine ones.

Baltimore, Maryland 21215-0036

death with the Maryland

Certification: To in by the

1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

29c. License number RES-000 29d. Date signed (Month, Day, Year)

30. Name and add ass of person who completed cause of death (Item 23a) (Type, Print)

2007

Eastern Avenue Baltimore mayind

State Registrar

Medical

Detern 4940 31. Date filed (Month, Day, Year) JAN 3 1

2. Registrar's Signature

after death Director:

To the Hospital within 24 hours at To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day January 23, 2007 Medical Examiner 1735 hrs RAYMOND EARL DAVIS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of **Funeral** Months Days Hours Director Country) 1 X M 2 59 08/02/1947 Usual Residence of Deceden any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 X Yes 2 No BALTIMORE death with the Maryland MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 1704 PRESSTMAN ST Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. Never Married 2 X Married 2 X No Yes 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify BLACK "natural", ð 72 hours 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12TH BAKER BAKERY 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be GRACE HOPEWELL CHARLES B. DAVIS ပ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3127 WHEATON WAY - APT. A, ELLICOTT CITY, MD SHIRELLE DAVIS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 5712 O'DONNELL ST. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit Page Department o 01/30/2007 BALTIMORE, MD 21224 CARMEL CEMETERY Donation 5 Other Specify 21. Signature of Funeral Seprice Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231 or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only cause on each line Retween Onset and /Medical Death Immediate Cause (Final disease Metastaitc lung carcinoma Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - trans sician/Medical XUNPENDED ^{AMENDED} , 27, perME, g864 2/21/07 ТТ Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Year Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records. 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? 2 No ✓ Yes 2 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes Nursing Home 5 Residence 6 Other ٩ 2 No 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: X Natural 5 Pending Yes 2 No Director: the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 3 Suicide Could not be within 24 hours at To the Funeral I determined 4 Homicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E January 24, 2007 30. Name and address of person who completed cause of death (Item 23a) 0 Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar Drillyn 17 Rev 1/2001

OCME 2006

State

31 Date filed (Month, Day, Year)

Registrar's Signature

07-00797		Please Type or Print in Black Indelible In			
Kevin B. Evans, J		State of Maryland / Department of Certificate of		ene Reg. 1	2007 0248
Physicia Medical Examin	n/	Redistrar 1. Decedent's Name (First, Middle, Last) Nevin Buron Evans, Jr.	M	ate of Death lonth Da nuary 28, 2	3. Time of Death
		Facility Name (if hot institution, give street and number) Northwest Hospital	b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore County
Funeral		Social Security Number	If Under 1 Year If Under 24Hrs. 8. Months Days Hours Min.	Date of Birth (N	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		219·27·7001 1XM 2 F 17 Yrs. Usual Residence of Decedent		51.07.	1990 Country) MD
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vith the Maryland s 23a or 28a-f show a e meiffied at once.	ector	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
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Jeath v	Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 N No	es, specify Cuban, Mexican, Puerto Rica		White, etc.
urs after tural",	<u>۾</u>	or Dates:	Yes 2 X No specify: I's Usual Occupation (Give kind of work o	done 16	Specify: 15 GCK Sb. Kind of Business/Industry
36 thin 72 hours after than "natural", edical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use retired)		(1)
5-0036 led within 7 Hygiene Lother than the Medica	E COM	17, Father's Name (First, Middle, Last)	Student 18.Mother's Name (Firs	st, Middle, Maid	Student den Surname)
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imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene taut: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	2	Brenda Evans / Mother 15L.	Ald Coach I ane		o Mill MD 2017
ore, MD ges I and 2 sho t of Health and : If item 27 is	1	20a. Method of Disposition 20b. Place of Disposi 1 VBurial 2 Cremation 3 Removal from State	ition (Name of cemetery, Date place)	te 2	0c. Location - City or Town, State
Baltimo permit. Page Department o Important: injury or oth	4	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. N	ame and Address of Facility Vaugh	2007	Baltimore MD
Balti permit. Departi Import injury		Vaughi C. Greene 187	28 Liberty Rd Man	dallota	41.00 A1.33
Physician /Medical		Depth is the control of the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease as Multiple Gunshot Wounds)	ne mode of dying, such as cardiac or resp	oiratory arrest,	shock, or heart Approximate Interval Between Onset and Death
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	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
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68760, certificate be nding physici se as the buri	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d Date of delivery
, P.O. Box 68760, ires that the death certificate be essigned by the attending physicial be detached for use as the burial	Physician/Medi	past 12 months? 4 Pregnant at time of death 5 Oth	tal death 3Ectopic pregnancy ner (Specify)		Month Day Year
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nl Re m: The rrificate tor, pag		25. Was case referred to medical	26.Place of Death (Check only	1 Yes 2 one)	No 1 ✓ Yes 2 No
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Division tal or Attendir us after death. al Director: A	ertification	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree	et, factory, office building, etc. 28f.	Location (Stre	et and Number or Rural Route Number, City
lospital Hours Inneral	Cer	4		old Coach La	ne, Owings Mills, MD
Division To the Hospital or Attendin within 24 hours after death. To the Finneral Director: A completely filled in by the fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated	ion, in my opinion, death occurred at the	time, date and	d place, and due to the cause(s)
	Σ	29b. Signature and title of gertifier	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year) January 29, 2007
- n		30. Name and address of person who completed cause of death (Item 23a)			
	ate	Susan Hogan MD. Assistant Medical Examiner 111 Pen 31. Date filed (Month, Day, Year) 132. Registrar's Signature	n Street, Baltimore, MD 21201	5.	
Regist		171N G 1 2007 No 2 2 Consta	<i>y</i>		

07-00663 Tio Danele Floye		Please Type or Print in Black Indelible Ink. Ensure All of State of Maryland / Department of Health and Mer Certificate of Death		е	2007	0218
Physicia	_	1. Decedent's Name (First, Middle,Last)	2. Date	Reg No.		ne of Death
Medical Exami		TIO DONNELL FLOYD	Mont Janu	bary 23, 2007	Year 23	00 hrs
-		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location			ounty of Death	
i.		Johns Hopkins Hospital Baltimore				
Funeral		Months I Days Hour		te of Birth (MM/DD	/YYYY) 9 Birthplace Foreign	,
Director		220-98-9999 1 M 2 F 24 Yrs.		6/30/198	2 Country)	MD
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>	.	DATESMODE				Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	MD BALTIMORE 10e. Street and Number 10f. Zip Code		10g. Citizer	of What Country?	
or 28	ire				,	
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or item	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexical Yes 2 X No	in, Puerto Rican, e	etc.)	White, etc.	
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	y:	Sp	ecify BLACK	
2 hours after "natural",		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give during most of working life. DO NO		e 16b. Kind	of Business/Industry	,
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5-0036 led within 7 Hygiene other than	Ë	10TH FORKLIFT DRIVER 17. Father's Name (First, Middle, Last) 18.Moths	orla Nama (First B)	Middle, Maiden Sui	AREHOUSE	
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212 ould be Ments mark c even	To B	CHARLES E. FLOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu			or Town, State Zip Co	ode)
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 of Health and Mental Hygiene (firen 27 is marked other than 1 her traumatic event, the Medical		DELSORA HYMAN/MOTHER 26 HORSERADISH A				
e, N I and Health item	Ì	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Loc	ation - City or Town,	State
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Baltin permit P Departme Importan injury or	1	4 Donation 5 Other Specify: MT CARMEL CEMETERY 21. Signature of Feral Specify: 22. Name and Address of Facilit				
	- 1	Mesia han the 2007-09 EAST		-		21231
Physician		23a. Part I. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as failure. List only one cause on each line.	cardiac or respira	tory arrest, shock,		oximate Interval
/Medical Examiner	ı	Immediate Cause (Final disease a. GunShir wound to head				Death
		or condition resulting in death) Due to (or as a consequence of):				. "
Marine and a second	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Ē	cause Enter Underlying Cause				
چ چ ر و	Examiner	events resulting in death) Last Due to (or as a consequence of):				
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Box 68760, e death certificate b the attending physical for use as the but	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectop	oic pregnancy		ate of delivery onth Day	Year
X 6 th cer trendi	isi	4 Pregnant at time of death 5 Other (Specify)				
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Rec The Is cate h	ĕ		1	performed? Yes 2 No	death? 1 ✔ Yes	2 No
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In of Vital Records, P.O. Box 68760, ling Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	10	1 Yes 2 No Inospiral 1 Inpatient 2 ER/Outpatient 3 DOA	Nursing Home		e 6 🗸 Other: Scene	· · · · · · · · · · · · · · · · · · ·
n of		27. Manner of Death 28a Date of Injury 1 Natural 5 Pending 28b Date of Injury FOUND: 28b Time of Injury FOUND: 1 Yes 2 ▼	Subjec	escribe how injury of ot shot	occurred	
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires that the death certificate be executed the Funeral Directors. After this certificate has been signed by the attending physician and piletely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	or 7	Town, State)	Number or Rural Rou et, Baltimore, MD	ite Number, City
the Hospital ain 24 hours the Funeral		29a. Certifier 1 Certifician Physician To the best of my length days double accurred at the time days and a				
the Hos hin 24 ha the Fun	lical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of		, ,		e(s)

To the Hospi within 24 hor To the Funer completely fi

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

29b. Signature and title of certifier

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

January 24, 2007

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3 Time of Death Day Year **Physician** 12:08 PM Ruth Elizabeth Fitzpatrick 2007 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore 8820 Walther Boulevard #3505 if Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) September 28, 1918 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🗓 F 88 Yrs. 210-01-0493 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ?7 is marked other then "netural", or liems 23a or 28a-f show treumatic event, the Medical Examiner must be notified at Baltimore Baltimore 1 ☐ Yes 2 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21234 8820 Walther Boulevard #3505 by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ [X] No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) A & P Food Company Stenographer 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen Tully Edward Habnicht ဥ 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tre-once. 3300 North Ridge Road Suite 385 Ellicott City MD 21043 Roland R. Bounds/Attorney 20b. Place of Disposition (Name of cemetery, cremetory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Marriotsville Maryland 1/29/07 Crestlawn Mem. Gardens 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Leonard J. Ruck, INc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee iller 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ After this certificate has been signe funeral director, page 2 should be pertension 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 5 Residence 6 □Other (Specify) 28c. Injury et Work? 27. Manner of Death 28e. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours e To the Funerel D 29a. Certifier Medical Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner steted. 29b. Signature and title of centifier 29d. Date signed (Month, Day, Yeer) 5 lvd, Parkrille, Na 15her Year) 31. Date filed (Month, State Registrar

07-0069	92	
William	Franklin	Fields

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and the same of th		Willia 4a. Facility Name (if not instituti	m Fra- ion, give street and no	nklin umber)		ie1ds 4b. City, Town,	or Location		anuary 2	24, 2007 4c. County of	1659 l	nrs
		7917 St. Gregory Driv	ve			Dundalk				Baltimore		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs,	last birthday)	If Under 1 Ye	ear If Und	1.1		rth(MM/DD/YYYY)	9. Birthplace (Star Foreign	ite or
Director		216-62-0467	1 X M 2 F	51	Yrs		iys Hour	s Willi.	reb.	2,1955	Country) Maj	ryland
any		Usual Residence of Decedent 10a. State 10b. County	-	10c. City	, Town or Locat	ion						e City Limits
and show nce	ا ا	Maryland Ba	altimore			Du:	nda1k				1 Yes	2 X No
Maryla 28a-f	Director	10e. Street and Number				10f. Zip Code				0g. Citizen of What	,	
th the 23a or	Ϊ́	7917 St. Gre						1222		United St	iates	
eath wi	Funeral	11. Marital Status 1 Never Married 2 M	Married Armed Fo			as Decedent of H es, specify Cuba				14. Race - White, e	American Indian, I etc.	Black,
ifter de	y Fu	3 Widowed 4 X Di	1 Yes	2 X No	1	Yes 2 X N	lo specify	<i>/</i> :		Specify:	White	
hours a	ed by	15. Decedent's Education (Spe		de completed)	16a. Deceden	nt's Usual Occup	ation (Give	kind of work o	done	16b. Kind of Busin		
36 in 72 han " dical E	Completed	Elementary/Secondary (0-12)	College (1 1 Year		Insta		e. DO NO	use retired)		Communic	cations	
5-00 ed with ygiene other t	Som	17. Father's Name (First, Middle					18.Mothe	er's Name (Firs	t Middle N	Maiden Surname)		
1215 be file ental H urked	Be (James F. Fie	elds							Dunbar		
D 2's should and Me 7' is ma 1's ma 1	To	19a. Informant's Name/Relations Jennifer A. F		uahter)	1					nber, City or Town,		
and 2 lealth :		20a. Method of Disposition	10100 (20		Place of Dispos			ce Driv		asedena,		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation		om State Oal	crematory or oth k Lawn (ner place) Cemetery	У	1/27/2	2007		nore, Mar	
altir mit. F partme portan ury or		4 Donation 5 Other S 21. Signature of Fune of Service			22. N	lame and Addre	ss of Facilit	ty				
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Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	e on each line		. Do not enter th	ne mode of dying	g, such as o	cardiac or resp	iratory arre	est, shock, or heart	Approxima	ate Interval Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)		tions of		lcoholis	n				De	eath
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ecuted and transit	Examine	(Disease or injury that initiated events resulting in death) Last		consequence o	():							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal	X UNPENDED	d.								_	
60, ate be o	Medical	IF FEMALE:	#23a,27	putcome of pregi	3865, 3/7/	<u>′07 TT</u>				Tool Barret		
687 ertifica ding p		23b. Was decedent pregnant in the past 12 months?	he 1 Live bi	irth	2 Fet	tal death 3	Ectopi	ic pregnancy		23d Date of de Month	Day	Year
Box 687; death certific	Physician/	1 Yes 2 No 9 Uni	known 9 Unkno	ant at time of de	eath 5 Oth	ner (Specify)				1		
P.O. E		Part II. Other significant condit	tions contributing to	death but not re	esulting in the u	nderlying cause	given in Pa	art I. 2	23e. Did tok	bacco use contribut	te to the cause of	death?
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Division of Vital Records, tal or Attending Physician: The law require rs after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed							2	24a. Was ai autops	sy prior	re autopsy findings r to completion of	
tal Reco	Con							1	✓ Yes 2		th? Yes 2	No
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n of Vit ding Physic After this funeral dire	10	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		ER/Outpatient 28b. Time of In		ury at Work	Nursing Hom		Residence 6 🗸 0	Other: Scene	
ision Attendin rector: A	aţio	1 Natural 5 Pend 2 Accident Inves	ding stigation	Day,Year)			Yes 2	.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
ivis lor At after d Direct	Certification:	3 Suicide 6 Coul	ld not be 28e. Place	of Injury - At ho	ome, farm, street	t, factory, office	building, et		ocation (St	treet and Number o	r Rural Route Nur	mber, City
Divi Ospital or hours afte meral Dir y filled in	è	4 Homicide	rmined (Specify)						or Town, Sta			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only Certifying Pr	hysician: To the best miner:On the basis o	of my knowledg of examination ar	ge, death occurr nd/or investigati	ed at the time, don, in my opinio	late and pla	ace, and due to	the cause	(s) and manner as	stated.	
To To COII	Me	29b Signature and title of certifie	and manner st	ated.		29c. Licens				29d Date signed		r)
		Alelina Si	assell.	M.D.		O.C.	M.E.			January 25, 2		/
, i	Ì	30. Name and address of person	·	,	,							
40		Melissa Brassell, MD 31. Date filed (Month, Day, Year) JAN 3 1	Assistant Med		1 1	enn Street, E	3altimore	∍, MD 2120	11			
St Regist	ate	JAN 3 1 2	2007	gistrar's Signatui	re A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #26, per MD G863, 1/31/07 TT Cartificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Joseph Michael Giunta 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location, of Death Examiner 4c. County of Death Franklin Square Baltimore Kosedale If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Director 69 06/19/1937 218-34-1773 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location la or 28a-f show t be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 11713 Mohr Road 21087 Funeral U.S.A. r than "natural", or items the Medical Examiner πι 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2X Married Completed by 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Quality Control Manager <u> Janitorial Services</u> other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ges 1 and 2 should be file it of Health and Mental Hi If item 27 Is marked oth Be Charles T. Giunta 2 <u>Linda C. Palmieri</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Giunta (wife) 11713 Mohr Road - Kingsville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 XOther (Specify) Mausoleum Gardens of Faith Cem. 01/30/2007 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HYPOGE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONARY OBSTRUCTIVE CHEONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1□ Yes 2 1NO 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 Ho 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 055306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

DENNIS-H. ODIE

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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	or 28	Director	10e. Street and Number				10f. Zip (1	-	en of What Cour	ntry?
	s 23a	Funeral I	831 E. Patapso	12. Was Decedent	. Francia II C	10.1	Man Donald	212		2 (Capaif.)	/aa az Na		J.S.A. 4. Race - Americ	ean Indian
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\leq	hould d Mei narke natic	2	19a. Informant's Name/Relationship			19h Mailir	na Address	(Street :		sie Mi		r City or	Town, State, Zip	Code)
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	is 1 and 2 of Health a item 27 Is other trai		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name	e of	1	Date		20c. Loc	ation - City or To	own, State
2			1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9	y Cros	-		1	1/30/2	2007	Ba1t	timore.	Maryland
saltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic		1	22	2. Name and	Addres	s of Facility	Gonce	Fune	eral	Service	. P.A.
	90 E 8 9		Tono	Mari	dge								e, Maryl	and 21225
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	line.	Do not ent	er the mode	or ayırı	g, such as car	rdiac or resp	oiratory ari	rest,		Approximate Interval Between Onset and Death
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8/60,		dical		d										•
×	ding p	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnan	icv							Od Data of dally	
X R Q	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pre					2	3d. Date of deliv Month	ery Day Year
o	w requires that the debeen signed by the should be detached	ysid	1 ☐ Yes 2 X No 9 ☐ Unknown	9□Unknown			30000 (470							
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<u>s</u>	Attendi death. ctor: A y the fu	cati	2 Accident Investigat 3 Suicide 6 Could not		niun/ - At hon	ne farm str	M eet factory		Yes 2□No		ocation /S	treet and	Mumber or Pur	al Route Number,
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		edical C		Physician: To the best amlner: On the basis and manner s	of examination									
	To the Hos within 24 hd To the Fun completely	Med	29b. Signature and title of certifier				29c.	. Licens	e number		:	29d. Date	signed (Month,	Day, Year)
	->-0		1 Charles	PHYSICI	AN			RE	5000		V	ANU	ARY, 26	, 2007
•	i		30. Name and address of person wh	no completed cause of	death (Item :									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #10a, perFH, 9503, 1/31/07 IT Cortificate of Department of State Amend #10a, perFH, 9503, 1/31/07 IT Cortificate of Department of Depar Reg. No. C 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:35 A M Month Year **Physician** Jaine 18 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number 16 Social Security Medical Bayview Center If Unde Hours 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) **Funeral** Months Days 1 M 2 K 218-82-2322 Usual Residence of Decedent Director aruland e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State S.C. 10b. County 10c. City, Town or Location nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No aucas Director 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian 11. Marital Status Black, White, etc 1 Yes 2 Is If Yes, Give Year or Dates: 2 300 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ears ana 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å and 2 should be ealth and Mental ပ 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Pri(t)) Shiloh Units Department of Health a Important: If Item 27 is any injury or other trau once. 20c. Location Pages 1 . Method of Disposition 3 Removal from State 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Road 1212 such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerchral Intrahee disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month signed by the atte in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/No 3 Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performe 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 1 Inpatient 2 ER/Outpatient 3 DOA 2 No ၉ this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 eiler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Bastern Bulhmore MD 21224 20 32 Registrar's Signature 31. Date filed (Month, Day, State

Registrar

2007

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:35 p.M Mae Johnnie 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 500d Samaritan NA Hospital If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 08 · 06 Birthplace (State or Foreign Country) **Funeral** 219.42.0990 1 ☐ M 200F Yrs. 101 Director Usual Residence of Decedent 10b. County t0a State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "natural", or items 23a or 28e-f show or other treumatic event, the Madical Examinar must be notified at MD Baltimore Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Koad 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Marned 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 MNo 131 ack þ Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade NIA permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be hessia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother Avenue Balto. MD 21218 incent 44031 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1

Burial 2 □ Cremation 3 □ Removal from State 01.27.07 Windsor Mill, MD King Manurial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility July In (. Greene Funeval Sewices 44105 York Road Baltmore MD 21212 21. Signature of Funeral Service Licensee an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** respirator /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by metabolic acidous 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? hypothermia 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Wa case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. nerel Director: A 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dr SABAEVA RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E. SABHEVA; GSH of Maryland, 5601 Loch Raven Blvd, Baltimore, MD, 21239-2995 32. Registrar's Signature 31. Date filed (Month, Pay, Year) State Registrar

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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28 2007 Month Physician /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 0 8. Date of Birth (Month., Day, Age (I 9 Birthplace Country) South Birthplace (State or Foreign Country) last birthday) If Unde 5. Social Security Number **Funeral** 216-18-9770 Months Days Hours Min 1 ☐ M 2 💆 F Yrs Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.
The filem 27 is marked other than "natural", or items 23e or 28e-f show and the than "natural", or prepared to the than the livilial at Invition at the prepared to the translation and the property or other translation and the property or other translation and the property or other translation and the property of the p 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No by Funeral Director VIa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 400 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced Slac Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use, retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) X 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ٩ 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if its any Injury or ot once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 200 21. Signature of Funeral Service Licensee uss F 23a. Part. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** VON -120 ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NOZUI 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Tes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Diractor; After this of in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

24 hours aft e Funeral Di letely filled in

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29b. Signature and title of certifier AHEND, Na

29d. Date signed (Month, Day, Year)

Jan 424 30 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SchwARTZMD

2007

and manner stated.

Newland

31. Date filed (Month, Day, Year) State JAN 3 1 Registrar

(Check only one)

32. Aegistrar's Signature

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	/sician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	230	c. If yes, outcom 1□Live birth 4□Pregnan 9□Unknown	n 2□Fet tat time of	al death 3	□Ectopic □ Other (s		у	-				ate of deli onth	very Day Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ZVeret /Medical Danuary 2007 Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ear If Under 24 Hrs.

ays Hours Min. 5. Social Security Number **Funeral** 7. Age (In sts. last birthday) Birthplace (State or Foreign
Country) 1**⊠**M 2□ F Days 50.00k Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified Director MD Baltimare 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? pe o Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23a or? ral", or Items 23a Examiner must b U.S.A Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 24Ears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Teorge Washington Hawkins

19a. Informant's Name/Relationship (Type. Print) Geraldine Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lele 12 Pair Avenue Beatrice Hawkins/Wife Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I Important; If ite any Injury or ot 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Forest 02.07.2007 Owing mills MD 22. Name and Address of Facility Voughi C. Greeke fureel service 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Road Rundallstown 1710 21133 Approximate Interval Between Onset and Death Immediate Cause (Final Physician main disease or condition resulting in death) MOXIC day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Cardiomyopa ears Due to (or as a consequence of) the burial-P.O. Box 68760. physician Physician/Medical for use as the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No autopsy Division or Vital 2 🗆 No Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Hospital: 2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; of completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Qertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 10 2001

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend # 20b, perFH, G863, 1/31/07 TI Certificate of Death Reg. No. 2 Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 28 Jan 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Agnes Baltimore. Hospital MD 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 6-28-9. 120 Yrs. Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ⊈ es 2 ☐ No saltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Koad Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use lettred) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Midelle, Last) 18. Mother's Name (First, Middle, Maiden ora Ma. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Himare 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fune II Service Licensee 5151 23a. Part1. Enter We disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** Lung Inknow /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): Division or Vítal Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwhith 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician,
completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: . If yes, *o*utc*o*me pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Medical Certification: To 1 Tyes 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28a 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062070 01/28/2007 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21229 900 Caton Weitong AVE. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

07-00654 Lillian Hucik

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Date of Death Month Day Yea **Medical Examiner** 1515 hrs January 23, 2007 illian Hucik 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9317 Old Harford Road Parkville **Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 6. Sex Months Days Min Foreign Hours Director 212-22-9954 89 **CSK** 2 **X** F 01/25/1918 M Country) Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits "natural", or items 23a or 28a-f show I Examiner must he notified at once. 1 Yes 2 X No MD Baltimore Parkville Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country 9317 Old Harford Road ö 21234 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X No Yes 3 X Widowed 4 Divorced 1 Yes 2 X No specify: If Yes, Give Year item 27 is marked other than "natural", rtranmatic event, the Medical Examiner Specify: ģ White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Nurse Medical 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Julius Muller Ludmilla Skrebski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Nielsen, Personal Rep 730 15th St. NW 3rd Fl., Wash. DC 20005 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth St. Joseph Fullerton 01/30/2007 4 Donation 5 Other Specify: Nottingham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Leonard J. Ruck, Inc. lexandra & Bates 5305 Harford Road, Baltimore, MD 21214 Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease complicated by hypothermia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Dide to (or as a nonsequence of): Examine Due to (or as a consequence of): attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Fetal death Day Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown Unknown signed by Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene 1 🗸 Yes 28a. Date of Injury FOUND: Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject exposed to low environmental Natural FOUND Pending 1 Yes 2 ✔ No 24 hours after death To the Funeral Director: Jan 23, 2007 1508 hrs temperature 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 9317 Old Harford Road, Parkville, MD determined (Specify) Single Family 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 24, 2007 30. Name and address of person eted cause of death (Item 23a) 6 Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month; Day, Y Year) 32 Kégistrar's Signature State 2007

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Mary		tificate of			2. No. 2 0 0 7	02494
Г	Physici	an	1. Decedent's Name (First, Middle, Last)	t to troutamon				Date of Death Month		3. Time of Death
W.	/Media	al	CAROLINA STEE 4a. Facility Name (If not institution, give s		<u> </u>	4h City Town o	r Location of Death	January	27, 2007 4c. County of Death	10:02 A
	Examir	er	202 Longwood Road			Baltin			N/A	
	Funeral		Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
16	Director		216-46-3734 Usual Residence of Decedent	W 2M	84 Yrs.			June 6,	1922 Puer	cto Rico
	/land low at		10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	e Mar ta-f sh tiffed	ctor	Maryland N/A	A	Baltim	ore City				1 XYes 2 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	,
	eath v	eral	202 Longwood Road 11. Marital Status	2. Was Decedent Eve	er in U.S. 13.		21210 Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Amer	ican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf Yes, specify Cuba 1 □ Yes 2[X]No		Rican, etc.)	Black, White	, etc. hite
21215-0036	2 hour	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	nation	ina 1	6b. Kind of Business/I	ndustry
215	ithin 7 ne. nan "n	Completed	(Specify only highest grade	College (1-4or 5+)	ł		during most of work d)	ing	Own Resid	longo
	iled w Hygier ther th	S	17. Father's Name (First, Middle, Last)	2 yrs	П	omemaker	18. Mother's Name	e (First, Middle, M		lence
lan	ld be lental ked o	To Be	_	Steele			Car	olina	Field	E
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	_	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State, Z	ip Code)
	and dealth		T. Crain Houston		P.O.		Butler, 1		21023 0c. Location - City or 1	Town State
nore	ages Intof H		1 ☐ Burial 2 【X Cremation 3 ☐ R	I	cemetery, cre	matory or other pla	ce)		•	· _
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funoral Service Liders		22	2. Name and Addre	ess of Facility		Baltimore,	
ä	permi Depar Impol any ir		Martin D. Law	son	6	500 York	Road, Bai	Itimore.	HOME, INC.	21212
		SECTION	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	metast		colon a	cancer			lo years
1	Examiner			Due to (or as a o	onsequence or):					
		ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	consequence of):					
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of).					
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687	ifficate g phys as the	edical								
Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf 1□Live birth 2 l	☐ Fetal death 3 [⊒Ectopic pregnanc	у		23d. Date of deli Month	very Day Year
.O.	he dea the at thed fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at tir 9⊟Unknown	ne of death 5[Other (specify) _				
0	s that the	y Ph	Part II. Other significant conditions con	ntributing to death but i	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords	en sig	ed b						1 ☐ Ye	s 2⊡″No 3□Pro	obably 4 □Unknown
Records,	Physician: The law requires that the de this certificate has been signed by the a al director, page 2 should be detached	Completed by						24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of
al F								1□ Yes 2	No 1 ☐ Yes	2 □ No
or Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth	ner:	th (Check only one	nce 6 □Other (Spec	zifv)
יס ר	ig Ph y ter this neral o	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury	of 28c. Inju		28d. Describe ho		
Division	tendir leath. tor: A	catic	2 Accident investigation 3 Suicide 6 Could not be	29a Plans of injury	- At home, farm, st	-]Yes 2□No	29f Location (Str	eet and Number or Ru	ural Pouto Number
Divi	after of Direct of In Direct of	Certification:	4 ☐ Homicide determined	building, etc.		icot, idotory, omico		City or Town,		rai i ioate ivambet,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or ir	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	00		29c. Licens	se number 3936	29	d. Date signed (Month	n, Day, Year)
	<		Jawa to	me &	th /Itam 222) /Time		3174		1211	
	8		30. Name and address of person who or Thomas Lansdale,				reet, Tow	son, Mary	yland 21204	+

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 3 1 2007

32. Pegistrar's Signature

25 2007

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Records, P.O. Box 68760, Division or Vital To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Medical Doctor Name and address of person who completed cause of death (Item 23a) (Type, Print) Ozdegirmenci 300 Baltimore Ave. MD 21229 Caton 31. Date filed (Month, Day, Cear) 32 Registrar's Signature State JAN 2 9 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible. amend 1 tem 29d per dvr 8863 1-31-07 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2007 MELVIN LEWIS HAWKINS, SR. January 2014 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12100 Hawk Hill Lane Little Orleans **Allegheny** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Min. 77 412-46-5272 June 6,1929 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Allegheny Little Orleans Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12100 Hawk Hill Lane 21766 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 "natural", or by 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) the Carpenter Self employed permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hansford Clayton Hawkins Susan Jane Saunders ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12100 Hawk Hill Lane, Little Orleans, Md. 21766 Melvin Lewis Hawkins, Jr. /son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gdns.02-01-07 Timonium, Md. 21093 4 ☐ Donation 5 ☐ Other (Specity) 22. Name and Address of Facility Ruck Towson Funeral Home, I 1050 York Rd., Towson, Md. 21. Signature of Funeral Service Licenses Inc. Richard G. Ruth un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deatl Immediate Cause (Final disease or condition resulting in death) MILULAIL I BEHYLAN **Physician** HOUI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar and Due to (or as a consequence of) physician Box 68760 pe Physician/Medical the attending p for use as use as IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months: 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b prior to c death? 1 ☐ Yes this certificate 2 No 1☐ Yes or Attending Physician: funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury s after deau. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Countying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. 29d. Date signed (Month, Day, Ye2007 address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) BALL State Registrar 200

Registrar

C. VERGARA - SOARES

Year)

1 2007

31. Date filed (Month, Day,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physician	
/Medical	
Examiner	

Funeral Director

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Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division or Vital

Physician /Medical Examiner

Examine death certificate be executed burial-transit and physician Physician/Medical attending for use ģ signed t Completed cate has t Be မ this After Certification: Hospital or Attending

within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical

31. Date filed (Month, Day, Year)

Day Month Year WALLACE JOHNSON JAN. 30 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALICE MANOR NURSING HOME BALTIMORE CITY
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country)
UNK Months Days Hours 1 M 2 □ F 82 217-14-8607 09/10/1924 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits N/A Director BALTIMORE CITY 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 ROCKROSE AVENUE 21211 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 NWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SAW MILL WORKER MILL INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK ပ UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code
10 N. CALVERT ST., BALTIMORE, MD 272 19a. Informant's Name/Relationship (Type. Print) MB 36196 ARDIE SHAW/LEGAL GUARDIAN 10 N. CALVERT ST., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/02/07 BALTIMORE, MD CARMEL CEM. 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, M 21. Signature of Funeral Service Licensee 23a. January Enter the Prease, or complications that caused the de United the American Struck of the American Stru Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Imm.di. Cause (Final dise e or condition resulting in death) voron Due to (or as a consequence of): Sequentially list conditions, if any leading to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Uvursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mn 07

Registrar

State

- ENTAW St Ante 308 BALTIMOREMIN

821

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	ırylanı		artmen			and M		giene	007	0	2499
										Date of Death 3. Time of Death					
200	Physici /Medic		Mat	ilda Mari	e Jo	hnson					Januar	y 23	200	7 7:	30 A. M
	Examiner							Town, or					c. County of Death		
			North Arundel H	ealth & Re	ehab.				Burni				Anne	Arund	el
	Funeral		5. Social Security Number 6. Sec	7. Age		ast birthday)	If Under Months	1 Year Days	If Under		8. Date of Birt (Month, Pa July 19	h y, Year)	9. B	Couldiny	State or Foreign
	Director		214 24 3949 Usual Residence of Decedent		78	Yrs.					July 19	, 19.	28 PE	ennsyl	vania
	land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Ins	ide City Limits
	Mary f sh	to	Maryland Baltimore Baltimore 1 Tyes 2X No									Yes 2X No			
	1 the	rec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?												
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Departments if Item 27 is marked other than "natural", or items 23a or 28a-f show mportant: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Extrating moral be notified at once.	O E	9300 Shady Creek Way 21234 U.S.A.												
		ner	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give			S. 13.	Was Deced	s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto F			ecify Yes or No-	. 14	14. Race - American Indian, Black, White, etc.		
9	or Ite	F					1 ☐ Yes 2√2 No Specify:			rican, otc.)					
9	ural',	Completed by Funeral Director	3 ⚠ Widowed 4 □ Divorced	Year or Dates:	ates:			TEL 103 ZACINO OPECNY.					Specify: White		
<u>7</u>	nati		15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usua kind of wor DO NOT us	k done	ation Juring most	t of workii	ng	16b. Kind	of Busines	ss/Industry	
12	the n		Elementary/Secondary (0·12) 12th	College (1-4or 5-	+)		Cutt)			∆ cme	Super	r Marl	/ot
Maryland 21215-0036	Hygie ther		17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,			IIGII	
an	d be ental	To Be		Shervani	ck						Benedict				
<u>Z</u>	shoul nd Ma mari		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	g Address	(Street a			I Route Numbe		Town, State	, Zip Code)	
Š	nd 2 alth a 27 is		Mary Amberg / Da	ughter		6311	Ritch	ie H	lighwa	ay B	altimor	e, M	ary1aı	nd 212	225
<u>e</u>	r Hear		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Nam	ne of	e)	Appropriate the second	ate		ation - City		
E	Page Tent of Iry or		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	1	view C				/25/	2007	Ba1t	imore	Mary	1and
Baltimore,	permit. Departminents Imports Eny inju		21. Signature of Funeral Service License	99	/				s of Facilit	y Gon	ce Fune	ra1	Servi	e. P.	Α.
œ	88 5 8	1.3	Jerome me	muselly	ni	40	01 Ri	tchi	e Hig	ghway	Balti	more	, Mary	land	21225
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
1760,	res ther the deam certificate be executed figned by the ettending physician end be detached for use as the buriat-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
.O. Box 68		edical Certification; To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Year			Year	
rds, P	The law requires thet the ste hes been signed by th page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba								acco use contribute to the cause of death? s 2⊠No 3 ☐ Probably 4 ☐Unknown				
Vital Record	The law re te hes ber age 2 sho										24a. Was autop perio 1 ☐ Yes		prior to death?	completio	dings available n of cause of
	ian: irtifice ctor, p														
<u>></u>	hysic his ce I dire		examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Description Other:									ecify)			
on of	ing P.										28d. Describe how injury occurred				
	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	ry - At ho . (Specify	/ - At home, farm, street, factory, office (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or within 24 hours after the Funeral Dir completely filled in		29a. Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Medical Examiner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one)												
	To th within To th compl	Me	29b. Signature and title of certifier	10	\bigcirc	1.0	29c	. License	number			29d. Date	signed (Mo	nth, Day, Yo	ear)
			•	Jack		NY	1.)0	057	84'	7	11:	24/2	005	7_
	2		30. Name and address of person who co	mpleted cause of de	ath (Item	23а) (Туре,	Print)	1	770	E 1	100	- 11.1	w		<u>'</u>
			9055 Cher	nolel	2	ue	JHe	ي ز	30	£7(i	CH C	ity	an	2104	12
	Sta Registr		31. Date filed (Month, Day, Year) 1AN 3 1 2007	32. Registra	r's Signat	ture)		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Calvin E. Johnson 4:50 P.M January 26 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director JANUARY 26, 2007 4:50 p.m. Baltimore, Maryland 21215-0036 Physician /Medical **Examiner** Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Division or Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

Stella Maris	s Hospice		Timon	ium		В	Baltimore			
5. Social Security Number 216 20 8297	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month. Da	th	9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				40.1 to the Otto Live			
Maryland Ann	ne Arundel	N. Lint					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?			
299 Regency			210			U.S.A.				
11. Marital Status	Armed For	dent Ever in U.S. 13. Vices?	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Ra Bla	ce - American Indian, ack, White, etc.			
1 ☐ Never Married 2 ☐ Man 3 ☐ Widowed 4 ☒ Divorced	I∐Yes 2⊠No	Specify:		Specify: White						
15. Deceden (Specify only highe	t's Education st grade completed)	(Give	lent's Usual Occupa kind of work done d	urina most	of workina	16b. Kind of E	Business/Industry			
Elementary/Secondary (0-12)	College (1- 5+ ye	4or 5+) life. L	Employed			Attorney				
17. Father's Name (First, Middle, A1:	^{Last)} fred Johns	on			's Name <i>(First, Middle,</i> a Norwood	Maiden Surna	me)			
19a. Informant's Name/Relations	hip (Type. Print)	19b. Mailin	g Address (Street a	nd Number	or Rural Route Numbe	er, City or Town	, State, Zip Code)			
Donald Johns	on / Broth	I	Streamvie				yland 21015			
20a. Method of Disposition		20b. Place of Dispos	sition (Name of	2)	Date		- City or Town, State			
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify)Entombment Loudon Park Cemetery 1/31/2007 Baltimore, Maryland										
1 Keome	mann	ween 40	01 Ritchi	e Hig	hway Balt	imore,	rvice, P.A. Maryland 21225			
23a. Part1. Enter the disease, or shock, or heart failure. List	omplications that ca only one cause on ea	used the death. Do not ente ch line.	er the mode of dying	, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between			
Immediate Cause (Final disease or condition resulting in death)		OCELLULAR CAN	ICER				Onset and Death			
	Due to (c	r as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Little Underlying b. Due to (or as a consequence of):										
Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequence of):								
	d									
IF FEMALE:	O20 Muse outs	ome pf pregnancy								
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live bir 4 □ Pregna 9 □ Unknow	Ectopic pregnancy Other <i>(specify)</i>				23d. Date of delivery Month Day Year				
Part II. Other significant condition	ons contributing to dea	th but not resulting in the unc	derlying cause giver	in Part I.	23e. Did to	bacco use cont	tribute to the cause of death?			
				1 Y	_					
					24a. Was a	n 24b.	Were autopsy findings available			
					autop:	sy med?	prior to completion of cause of death?			
25. Was case referred to medical				26 Place o	1 Yes f Death (Check only or		1 ☐ Yes 2 ☐ No			
examiner? 1 ☐ Yes 2 ┳ No	Hospital: 1 ☐ Inc	patient 2 ER/Outpatient	Othor				TOGET OF			
27. Manner of Death	28a. Date of	Injury 28b. Time of	28c. Injury Work?	at Auto	28d. Describe h		ner (Specify) HOSPICE			
1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation ot be	Day Year) Injury f injury - At home, farm, stree	M 1□Y	es 2 🗆 No)					
4 ☐ Homicide determi	building	, etc. (Specify)			City or Tow	n, State)	er or Rural Route Number,			
29a. Certifier Certifyin (Check only one)	g Physician: To the bas Examiner: On the bas and manne	est of my knowledge, death is of examination and/or inve r stated.	occurred at the time estigation, in my opi	e, date and nion, death	place, and due to the coocurred at the time, o	ause(s) and ma late and place,	anner as stated. and due to the cause(s)			
29b. Signature and title of certifier			29c. License	number	2	9d. Date signe	d (Month, Day, Year)			
	- 1 -		DI	177	125	1/2	19/07			
30. Name and address of person	who completed cause	of death (Item 23a) (Type, P	rint)	. / /		. /	/			
DR. TARIQ MAHMO	OOD 2300 1	DULANEY VALLE	Y RD. TI	MONIU	M, MD 2109	3				
31. Date filed (Month, Day, Year)		jistrar's Signature	make)							

DHMH 17 Rev 1/2001

State Registrar